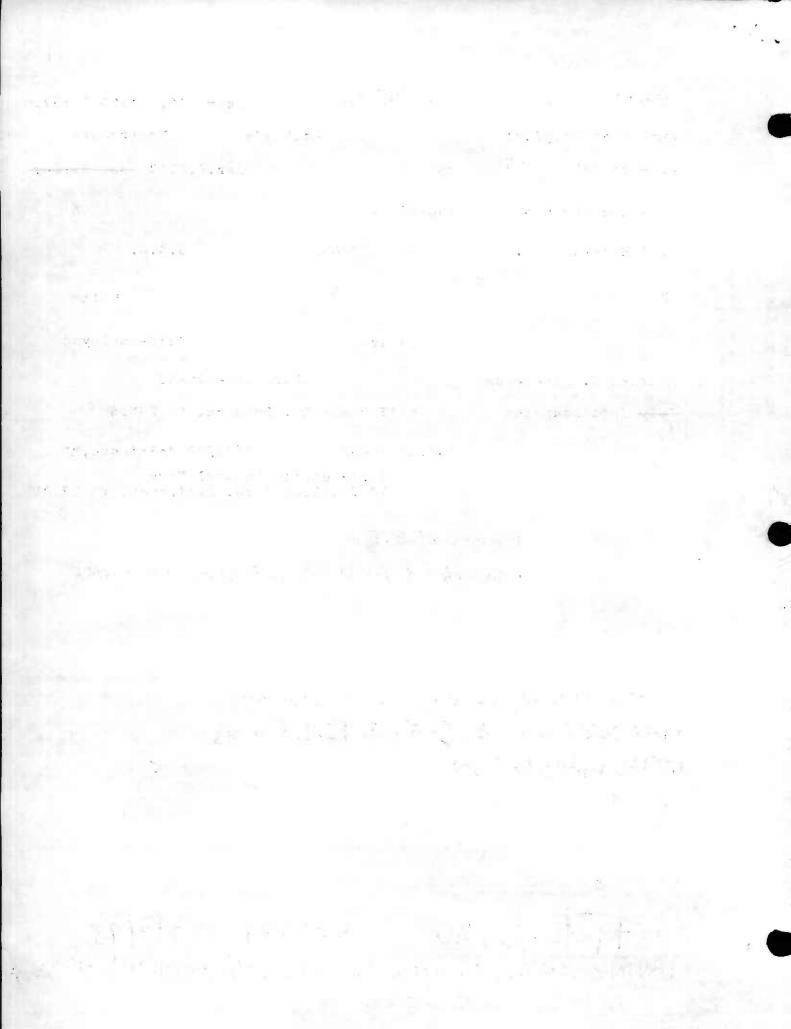
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend #9, 7/23/98, BMW, Montg.Co.State of Maryland / Department of Health and Mental Hygiene & Amend #19a,7/15/98, BMW, Montg.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth RAPOPORT Month RUTH **Physician** July 10, 1998 12:52pm /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** Surburban Hospital Montgomery Bethesda If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M · 2 🂢 F Yrs. Director 217-26-2160 Apr.6,1910 88 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Insida City Limits show "natural", or items 23a or 28a-f show 1 Yes 2 □ No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ត់ 6121 Montrose Rd. 20852 U.S.A. Funerai 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Yes No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNO Specify: 3 Widowed 4 □ Divorced White d be filed within 72 hou ental Hygiene. ed other than "natural event, ine Medical E 끃 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Caterer Self-Employed 18. Mother's Name (First, Middla, Maiden Sumema) 17. Fether's Name (First, Middle, Last) Be marked matic ev Maurice B. Middleman Clara Greenfield 19a Intorment's Neme/Relationship (Type, Print)
Judy
July Hutt/Daughter 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9417 Reach Rd. Potomac, MD 20854 pemit. Pages 1 a Department of Hos Important: If Item any injury or othe once. 20b. Place of Disposition (Name of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/98 Baltimore, MD Chizuk Amuno 21. Signature of Funeral Service Licensea 22. Name and Address of Fecility Ives-Pearson Funeral Home cal 2847 Wilson Blvd. Arlington, VA 22201 a 23a. Partt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Ceuse (Final disaasa or condition resulting in death) CARDIAL ARREST /Medical Examiner Due to (or as a consequence of): ARTERY DISEASE WITH ISCHEMUL Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Physician/Medicai thet initieted avents resulting in daath) Last Dua to (or as a consaquence of) Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? I LEUS, CHRONIC OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown COLON þ INTERSTITE FIBROS 24a. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to Completed complation of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 1/10/98 Ruth 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No Inpatient 2 ER/Outpetient 3 DOA ä 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 6 24 hours 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29a. Certifie To the Hosp within 24 hou To the Funel completely fil edical (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature at 29c. License number eted cause of death (Item 23a) (Type, Print) DEL RAY AVE BETHESOA, MD 208/4 RVING 4930 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State JUL 1 4 1998 Allie Davidson Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1998 JOHN LEMUEL ROGERS JULY 11 12:48 PM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) WORCESTER ATLANTIC GENERAL HOSPITAL **BERLIN** If Under 1 Year | If Under 24 Hrs. 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Yrs. DEC. 19, 1920 DELAWARE 221-12-3117 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MARYLAND WORCESTER BISHOPVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12938 OLD STAGE ROAD 21813 USA 14. Raca - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married It Yes, Give Year or Dates: 1945–46 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 WEIGHMASTER POULTRY 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSHUA ROGERS JENNIE STEVENSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) CATHERINE L. ROGERS/WIFE 12938 OLD STAGE ROAD, BISHOPVILLE, MARYLAND 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CAREY'S CEMETERY 7/15/98 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foreral Service Licenses HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. List only one cause or anothline. Approximate Intervel Between Onset and Death Sudden Cardiac Death Immediate Cause (Final disease or condition resulting in death) spiration of Stomach Contents
Due to (or as a consequenced): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknow 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of

1 ☐ Yes 2 ☐ No

*Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ATLANTIC GENERAL HOSPITAL ER

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner**

Physician

`Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or trsumatic event, the Medical Examiner must be

permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If item 27 is marked other any Injury or other traumatic event

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Physician/Medical Examiner

physician and s the burial-transit d guipui signed by the a should I is certificate has to director, page 2 s

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Completed

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1 Natural

2 Accident

3 Suicide

29a Certifier

4 Homicide

Certification:

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cartificate be axecuted 68760. P.0. Records, aw Division of Vital Attending Physician: this daath. To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completaly filled in by the fu

> State Registrar

MAUREEN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

PRENDER GAST

30. Name and eddress of person who completed cause ot deeth (Item 23a) (Type, Print)

32. Registrar's Signature JUL 13 1998 Juli Swelson Robell

28e. Placa of Injury - At home, farm, street, tactory, office building, etc. (Specify)

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DHMH 16 Rev 6/95

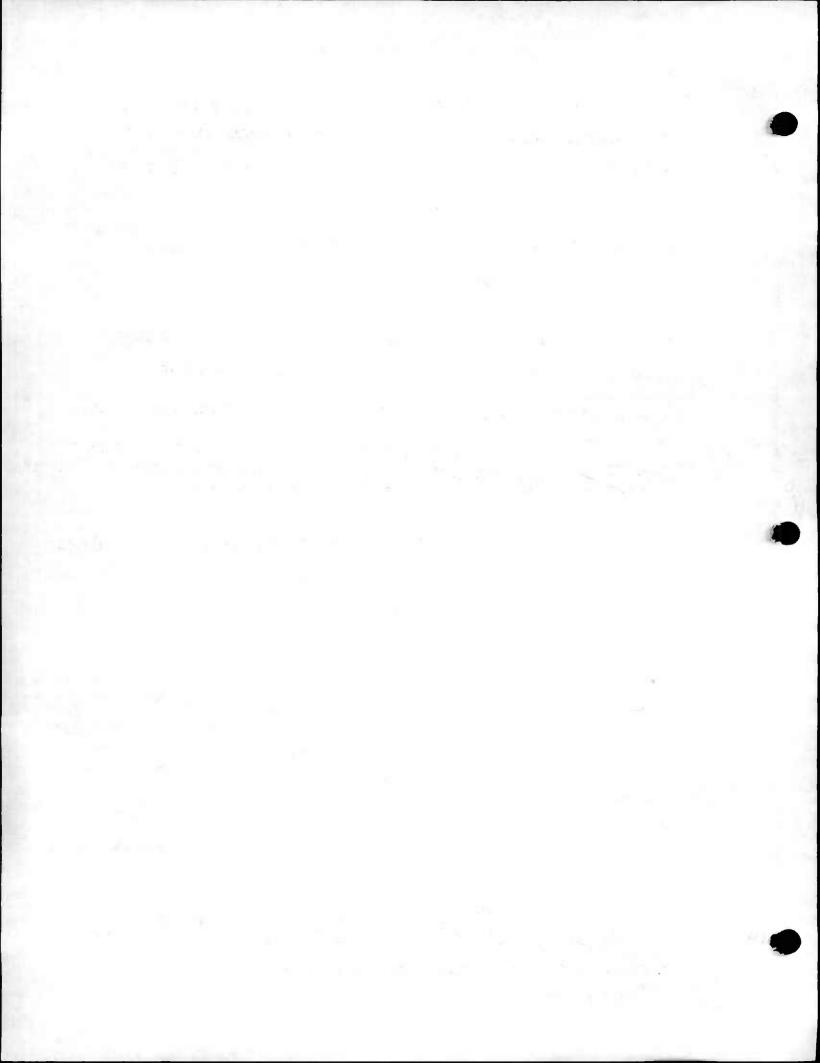
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** LETTIE RAWSON MALINDA JULY 14, 1998 04:30 am /Medical 4a. Facility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Death 4c. County of Daath **Examiner** PRINCE FREDERICK CALVERT CALVERT MEMORIAL HOSPITAL | Hours | Min. | 8. Data of Birth (Month, Dey, Yeer) | 9. Birthplaca (Steta or Foraign Country) | APRIL 22, 1907 | SOUTH DAKOTA 5. Social Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) **Funeral** 1□M 201F Days Months Yrs. **Director** 340-18-7246 Usual Rasidence of Dacadant 10a Stata 10b. County 10c. City, Town or Location PORT REPUBLIC 10d. Inside City Limits or 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at CALVERT MD 1 ☐ Yas 2 1 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20676 3131 MALORY SQUAIRE USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amaricen Indian, permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "naturelt, or iter any Injury or other traumetic event, the Medical Examinations. Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVT. CLERK 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname)
LURINA MINNIE SINKIE Be BEN ANDERS THOMPSON 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Address (Street end Numbar or Rurel Routa Number, City or Town, Stete, Zip Coda) PORT REPUBLIC, MD 20676 3131 MALORY SOUAIRE EARL WAYNE RAWSON (SPOUSE) 20b. Place of Disposition (Name of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Bunal 2 ☐ Cramation 3 ☐ Ramoval from Stata 7-21-98 SCHYLER, ILLINOIS 4 ☐ Donetion 5 ☐ Othar (Specify) CEMETERY SIMS 21. Signature of Furnity at Service License 22. Nama and Addrass of FacilityHINES-RINALDI 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter tha disaasa, or complications that caused tha death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betwean Onsat and Death **Physician** Congestive Heart Farlune
Atrix 1 Fibr: lation Immediata Causa (Final disaasa or condition resulting In deeth) /Medical **Examiner** Examiner or Attending Physician: The law requires that the death certificete be executed burial-tran Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in deeth) Last Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p ed by the a deteched i Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 2 XN0 1 Yes 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of causa of daath? this certificate 200 1 Yas 1 ☐ Yas 2 ☐ No 25. Was cese refarred to medical axaminar? Be 26. Place of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 2 1 Yas 2 10 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Injury 28c. Injury al Work? Certification: 28d. Describe how injury occurred : After t 5 Panding Investigation Natural s efter death.

i Director: Aft
d in by the fur 6 ☐ Accident 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At home, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) within 24 hours efter To the Funeral Direc completely filled in by 4 Homicida To the Hospital 12 Certifying Phyelclen: To the best of my knowledga, daath occurred at tha tima, data and plece, end dua to tha cause(s) end manner as steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and place, end due to the cause(s) end manner stated. Medicai 29a. Cartifier (Check only 29b. Signatura and Iill of cartifiar 29c Licensa number 29d. Dale signad (Month, Day, Yaer) 052242 30. Name end addrass of person who completed causa of death (Item 23a) (Typa, Print) Dr. Joseph J. Barth M.D Prince Frederick, MD 20678 32. Ragistrar's Signetura 31. Date filed (Month, Day, Year) State The Davidson-Randall JUL 1 6 1998 Registrar

DHMH 16 Bev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Yee Harold 1230 JUNE 19 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Edgewater An: If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) Pleasant Living Convalescent Center Anne Arundel If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**2** M 2□ F Months Days Yrs. 87 August 11,1910 New York 577-54-0740 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3051 Aberdeen Road 21403 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 XMarried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Scientist US. Public Health 17 Fether's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surneme) Matthew Arnold Robinson Louise Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Dorothy C. Robinson (wife) 3051 Aberdeen Rd. Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. 06/22/98 Brentwood, MD Lincoln Crematory 21. Signeture of Funeral Service License 22. Name and Address of Fecility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demutia Zyears Due to (or as a consequence of): Dehy drafin weeks Due to (or as e consequence of): piration Z weeks preumonia Due to (or as a consequence of): 23b. Did tobacco use-contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

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"natural", or items 23s or 28s-f show

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nding physician end use es the bunel-trans for

P.O. Box 68760, The law requires that the death certificate be signed by the a Division of Vital Records, should l pege 2 s has certificate Attending Physician: director After this

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Completed 24a. Was an autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

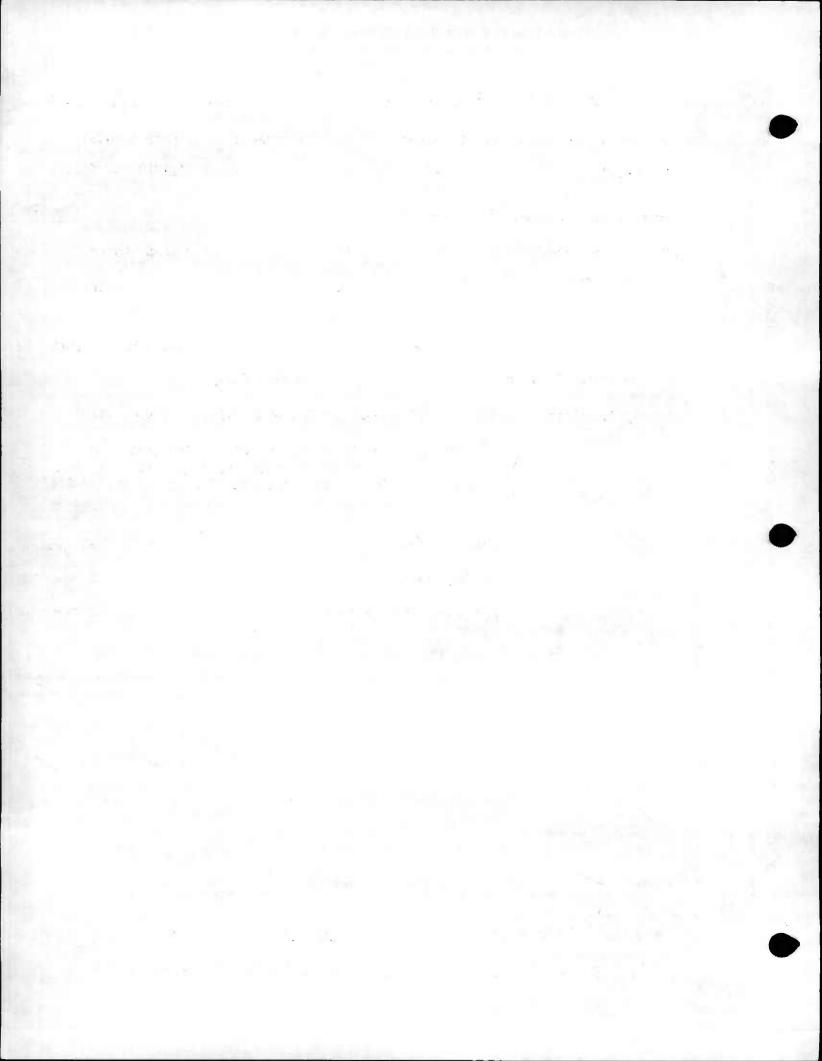
To the Funeral Director: After this completally filled in by the funaral is 27. Menner of Deeth 1 ■ Neturel 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end file of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUN 23 1998 32. Registrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Matthew J. 18. ? ? A Farest Drive, Annopulis Malta, 1 Yes 2 No

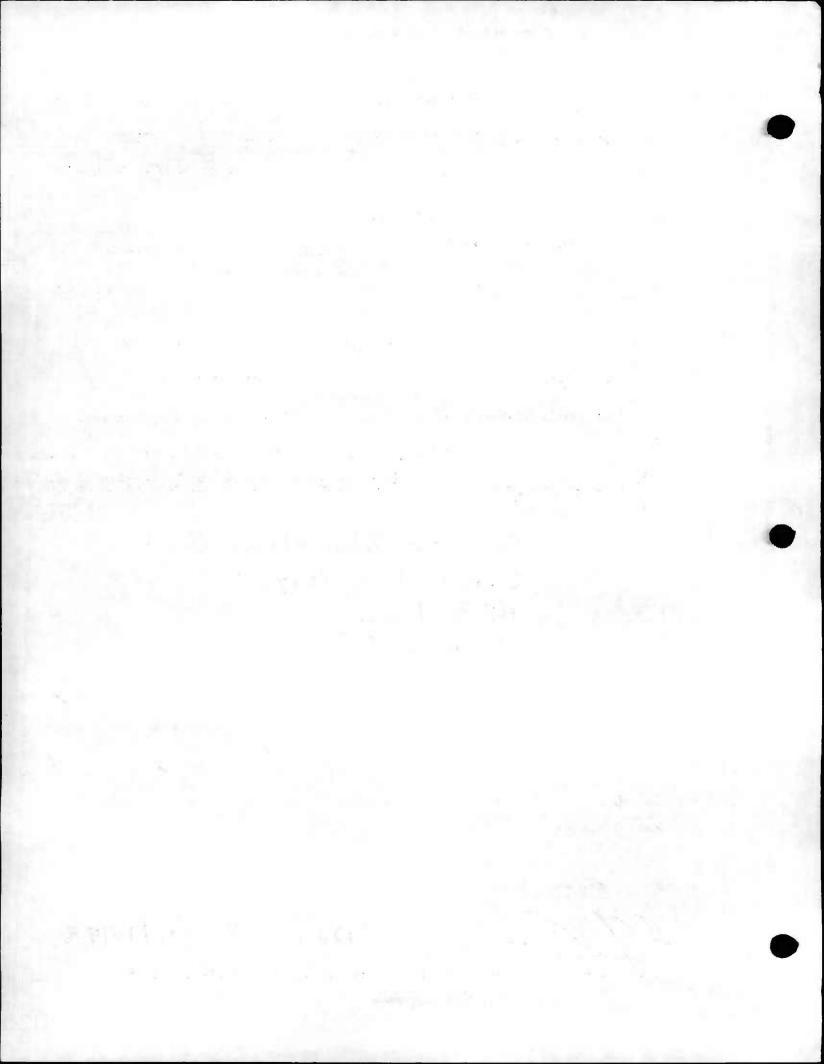
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State of Maryland / Department of Health and Mental Hygiene

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=	and and and and		19a. informent's Name/Ralationship (Type, Print) Raymond Rasamoelina/Son-in-Law 805 Montrose Road, Ro								er or Rui	rel Route Numi	ber, City	or Town,	State, Zip	Code)	
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of V	Q 50 X	0	examinar?	No	Hospital:	Inpatiant 2	ER/Outpatla	nt 3 DC	Oth Oth	nar: 4 🗆 Ni	ursing Ho	ma 5□Ras	idence	6 □Oth	er (Specif	y)	
	ding Ph h. After th funeral		27. Menner of Daath		28a. Deta (Mon	of Injury th, Day Year)	28b. Tima o injury	of 2	8c. Injui Wor	ry at rk?		28d. Dascribe	how inj	ury occur	red		
Division	Attending or deeth. ector: Afte by the fune	ati	2 Accidant	1 Maturai 5 Pending (Month, Day Year) Injury Work?													
5		IICat	3 Suicida 6 Could not be 28a, Place of Injury - At home, farm, street, factory, office										281. Location (Street and Number or Rural Routa Number, City or Town, State)				
-	re Atte		4 ☐ Homicida	_	288. Place	of Injury - At h	oma, farm, st	raet, factory	, office						er or Rure	l Routa Number,	
Ö	oltai or Attendi urs efter deeth rai Director: A illed in by the f	Certification:	4 Homicida	6 Could not be determined	288. Place buildi	ng, atc. (Spacii	fy)					City or To	own, Sta	te)			
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Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** 1:30 A.m 1998 ROSALEE M. STONER JUNE 20 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deat 4a Facility Neme (If not institution, give street end number **Examiner** ANNE HOSTITAL DURNIE HRUNDEL LOLEN RUNDEL If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiaca (State or Foreign **Funeral** Days Months 1 ☐ M 2 【XF 55 217-40-1891 MARYLAND Director Usuet Residence of Decedent with the Manylend 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylen Departmant of Haalth end Mental Hygiana. Important: if Itam 27 is merked other than "natural", or Itama 23a or 28a-f show any Injury or other traumetic event, the Medical Examinet must be notified at 1 ☐ Yes 200No Director ANNE ARUNDEL PASADENA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 1584 WALL DRIVE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes A No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bteck, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 XXo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be BUSTER LOWMAN MARJORIE UNKNOWN 10 19a. Informant's Name/Reletionship (Type, Print) 19b. Maiting Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) FRED E. STONER - HUSBAND 1584 WALL DRIVE, PASADENA, MD 21122 20b. Plece of Disposition (Neme of cometery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXuriet 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify BALDWIN MEM. CH. CEM. 6/23 MILLERSVILLE, MD of Funeral Service L RAYMOND Actions FINEY FUNERAL HOME OF GLEN BURNTE 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061 Do not enter the mode of dylng, such es cardiac or respiretory errest, Approximete Interval Between Onset and Deeth **Physician** /Medical a myocardiel disease or condition resulting in death) Intere 10 Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requiras that the death certificate be axecuted burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): and Records, P.O. Box 68760, physician that initieted events resulting in death) Lest the Due to (or as e consequence of) for Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by d be datacl 1 Yes 2 No 3 Probably 4 d Unknown 9RANVlomatosus Wegener's þ 24b. Were eutopsy findings eveilebte prior to completion of ceusa of deeth? 24e. Was en eutopsy Completed paga 2 1 Ves 2 | No certificate 1 MYes 2□ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 10 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, State) 4 Homiclde 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only one)

edicai 29b. Signeture and title of certifier

> 30. Name end address of person who completed lause of deeth (ttem 23a) (Type, Print) IRA E. KAPLAN, M.D.

> > JUN 24 1998

7845 OAKWOOD ROAD, SUITE 300, GLEN BURNIE, MD 21061

29d. Data signed (Month, Dey, Year)

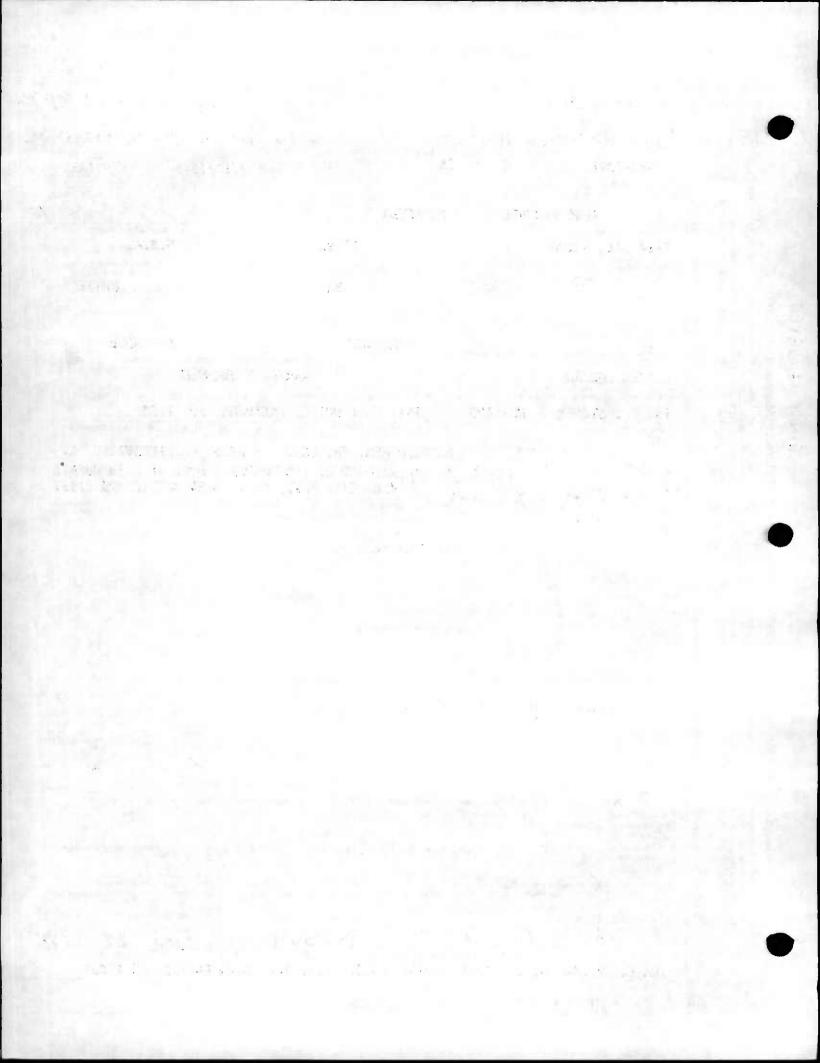
29c. License number

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

Lilia Davidson-Randall

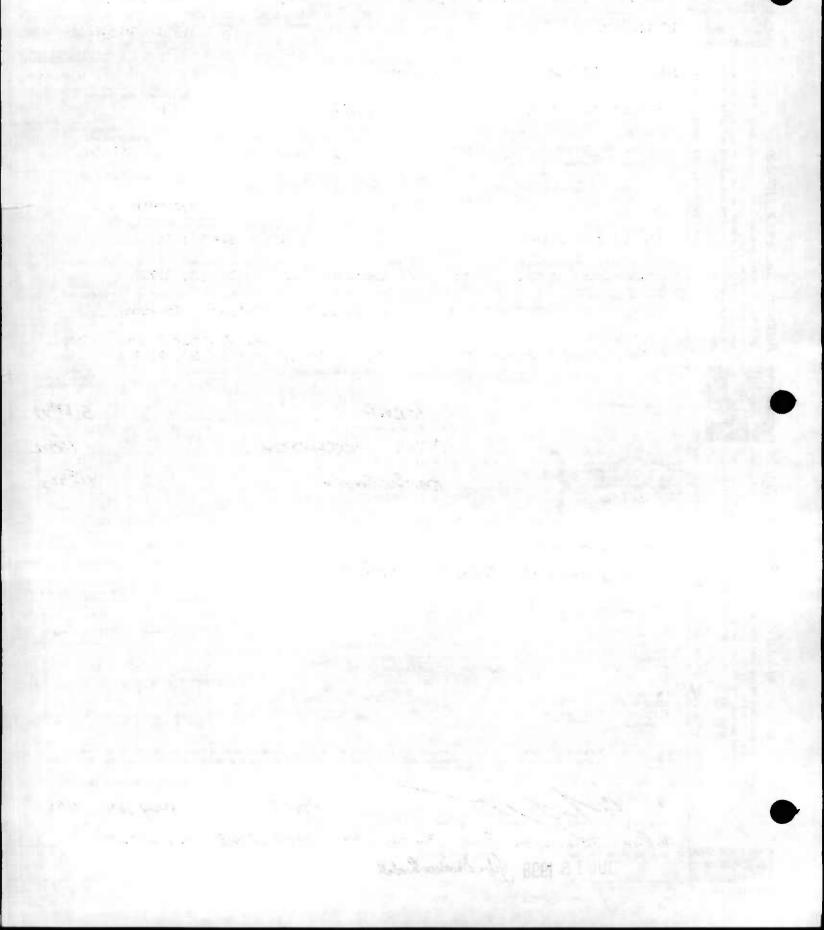
STONER, ROSALEE



State of Maryland / Department of Health and Mental Hygiene 98 23007

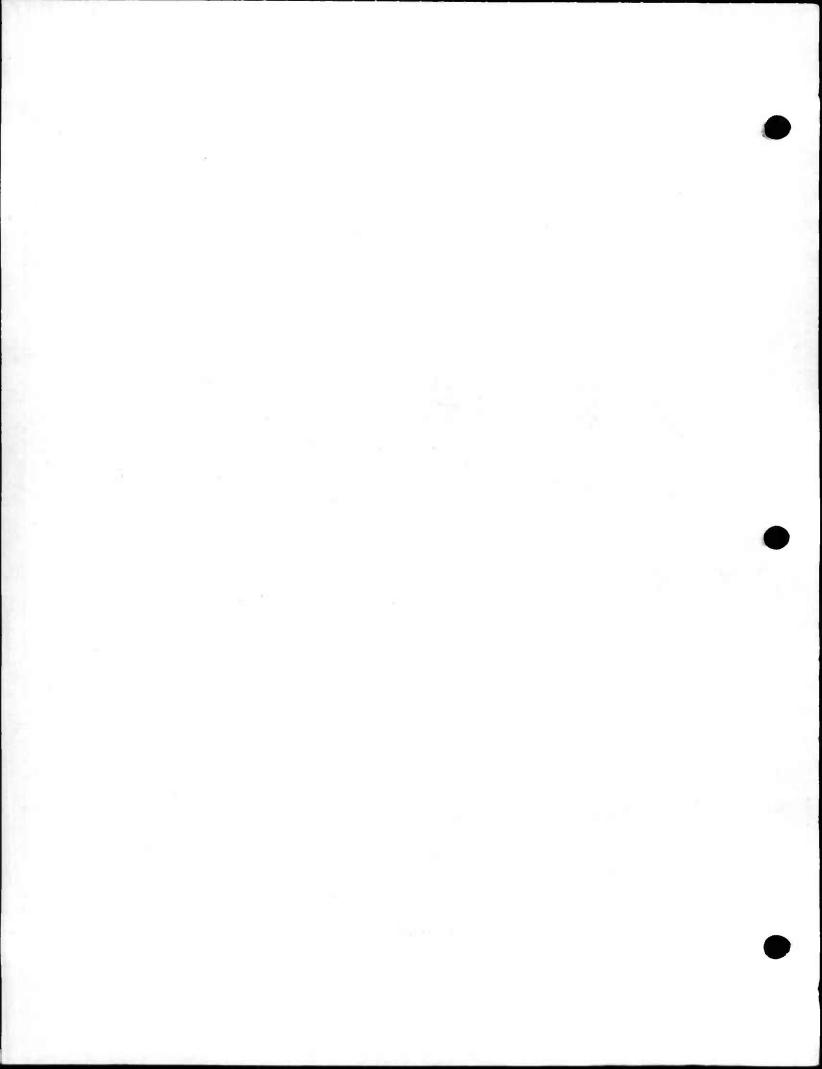
						Cer	tificat	e of	Death			Reg. No.	-	.0007	
	Physician /Medical		ama (First, Middla, La Murat	Seiber	t						2. Date of De July	-	8 Yaar	3. Time of Death 1:35pm	
	Examiner	4a Facility Name Montgon	(If not institution, givery County	re streat and numbery General	"Hospit	al			4b. City, To Olney		ocation of Daar	tion of Death 4c. County of Death Montgomery			
	Funeral Director	5. Social Security 218–14–0		Sax 1 Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					8. Data of Birth (Month, Day, Year) Aug 27 1913 9. Birthpla Virgi			placa (Stata or Foreign ntry) Inia			
Maryland	a-f show	Usual Rasidence 10a. Stata Md.	10b. County Howard		10c. City, To	own or Lo	cation							10d. Insida City Limits 1 ☐ Yas 2X No	
h with the	3a or 28a-f e		Number scommon Dr.	ive	H		10f. Zip 217					10g. Citizan of USA	What Cou	intry?	
5-0020 72 hours efter death with the Mandand	hatural', or items 23a or 28a-1 show edical Examiner must be notified at leted by Funeral Director	3 ☐ Widowed	s arriad 2 Married d 4 Divorced	12. Was Decedal Armed Forca 1 Yas 2 If Yas, Giva Yaar or Data:	s? No	1	Vas Deced Yes, spec	city Cub	an, Maxicer	igin? (Sr n, Puarto	pecify Yas or No Rican, atc.)	Bla	14. Race - Amaricen Ind Black, White, atc. Specify: White		
121 within	than the Me	(Sp Elementary/Se 12	15. Decedant's E pecify only highast gra econdary (0-12)	ducetion ade complated) Collaga (1-4c	v 54)	16a. Dacedant's Usual Occu (Giva kind of work dona lifa. DO NOT usa retire farmer			upation a during most of working red)			16b. Kind of Business/Industry		ndustry	
pul ed	d oth	17. Fathar's Nam	na (First, Middla, Last Churman Se						18. Mother's Name (First, Middle, Meiden Surmame) Nettie Leeds Willis (Street and Number of Purel Route Number City of Town State Zio Code)						
	tract tract	19a. Informant's	19a. Informant's Name/Raiationship (Typa, Print) Olivia Elmira Seibert (Wife) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Ste 3250 Roscommon Dr. Glenelg, MD. 21737										p Coda)		
Baltimore,	nt: If Item 2 iry or other		Disposition 2 Cramation 3 Cn 5 Other (Special		20b. Place cema Oak	atary, cren	sition (Name of the Cem	othar pia	ry	7.	Data -15-98	20c. Location Glenwoo	-		
Balti.	Department of F Important: If ite any injury or of once.		Funaral Service Lice ye Haight		*				ass of Facili	Ha		neral H Md. 231		Chapel	
Die	nysician	23a. Part1. Ente	r tha disaasa, or com aart failura. List only	plicetions that ceus	ad the death. D								704	Approximata Interval Batwaan Onset and Daath	
1	Medical kaminer	Immediata Caus disaasa or cond resulting in deat	ition	a		STRO	KE							5 DAYS	
	ě	The second second			Due to (or as	a conseq	-		450	2.1				146	
ox 68760, certificata be axecuted	ding physician and se as the burial-transit												5 DAY) 14 GARS		
	for us	Part it Other etg	pidicent conditions	d.	hut not requitie	o in the w	adadulas a	anno ci	uen in Rad		22h Dio	I tohacco use c	ontribute	to the cause of death?	
cords, P.O. Be	signed by the ad be detached by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. I SUHEMIC HEAST DISEASE									23b. Did tobacco use contribute to the cause 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4		obably 4 Unknown		
of Vital Records Physician: The law requires	s been 2 shoul plete			1								s an autopsy ormad?	a	Vara autopsy findings vailable prior to omplation of ceusa f daath?	
<u>a</u>	page . page										10	Yas 2 No	1	☐ Yes 老₩ No	
of Vita Physician:	certificate rector, pag	axaminar?	ferred to medicel	Hospital:				Ot	har:		th (Check only				
	th. : After this c e funeral dire		5 Pending			Outpatien b. Tima of Injury		28c. Inju	4 🗆 🛚 🕦			how Injury occu		ily)	
Division	rs aftar death. at Director: After t led in by the funera Certification:	3 ☐ Suicida 4 ☐ Homicid	6 Could not b	Zoa. Place of	Injury - At homa atc. (Spacify)	, farm, str	aat, factor	y, office				(Streat and Num own, Stata)	nber or Ru	ral Routa Number,	
Hospita	within 24 hours aftar deat To the Funeral Director: completaly filled in by the Medical Certifical	29a. Cartifiar (Check only one)		nysician: To the bearing: On the basis and mannar	of axamination										
Toth	To the comp		nd title of certifier	111		_	290	_	2594	7		29d. Data sign			
,		30. Nama and ac	drass of person who	em platad cause o	death (Itam 23	a) (Type,		,	crape	KSV	ine	my hi	018		
	State Registrar	31. Date filed (M	onth, Day, Yaar)	998 32. Aegis	strar's Signatura										

DHMH 16 Rev 6/95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	SIMIE UF	MAKYLANU / CE		ICATE OF			WENTAL HYGH REG. I			
	1. DECEDENT'S NAME (First, Middle, Last)				TOATE OF	DLA		2. DATE OF DEATH		3.	TIME OF DEATH
Susan Y. Spangler July 12									DAY 1.0	YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	1/_		2 · 1 OP M M
	176-44-0376	1 M 2 7 F	50	YRS.	MONTHS DAYS	HOURS	MIN.	(Month, Day, Year		Country)	(
	9e. FACILITY NAME (If not institution, give s	7	50		9b, CITY, TOWN	OBLOCATI	ON OF DE	March 1		PA PUNTY OF DEAT	*u
cc		area and morniber)						AIR	9c. CO	UNIT OF DEAL	н
일	5736 Conover Rd.				Taney	town			Ca	arroll.	
<u>a</u>	10e. STATE 10b. COUNTY	Y		10c. CI	TY, TOWN OR LOCA	TION				10	d. INSIDE CITY
DIRECTOR	MD Car	roll		Та	neytown					1	LIMITS?
	10e. STREET AND NUMBER			La		1. ZIP COD	E		10g. CI	TIZEN OF WHA	
8	5736 Conover Ro	1								TICA	
FUNERAL	11. MARITAL STATUS		NT EVER IN U.S. AR	MED	13. WAS DE	1787	OF HISPAN	IIC ORIGIN? (Specify	Vee or No.	USA 14 BACE -	American Indian
	1 Never Merried 2 Merried	FORCES?	NT EVER IN U.S. AR 1 YES 2 N WAR OR DATES	10	ff yea, s	ecify Cuba	ın, Mexice	n, Puerto Ricen, etc.)		Black, W	American Indian, hite, etc.
BY	3 Widowed 4 Divorced	IF TES, GIVE	MAR OR DATES		1016	2 2 NO	Specin	<i>/:</i>		Specify:	White
									BUSINESS/II	NDUSTRY	
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)											
Elementary/Secondary (0-12) College (1-4 or 5+) None None											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None None None 18. MOTHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surnant NAME (First, Meidel, Meiden S									den Surname)	
10s INFORMANT'S NAME (Fund/Print) 10s Mall INC apprece (Cheek and Alumber or Pund Goule Alumber City or Cheek To Code)									Zip Code)		
Arlene C.Spangler-Mother 5736 Conover Rd. Tanevtown MD21787									-		
	20a. METHOD OF DISPOSITION		-		OF DISPOSITION /A		Tai			- City or Town	State
	1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from Stata	cemetery, cre	matory or	other plece)			1			
4 □ Donation 5 □ Other (Specify) Mt. View Cemetery 7/15/98 Harn 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									ey, IID		
0 1 1 1 1 1										++1+	DA170/
Littles'F.H.34 Maple Ave.Littlesto											own, PAI / 34(
	23. PART i. Enter the diseasee, or shock, or heart failure.	List poly poe ca	at ceusad the de	ath. Do	nDt antar the m	ode of dy	ing, suc	h ss cerdiec or re	epiratory s	srreet,	Approximate interval Batween
	IMMEDIATE CAUSE (Fine)						/				Onsat and Death
	diseese or condition resulting in desth)	ce	ute s	edi	riata	cy	da	Prese			
1 1	Tooling in dealing	DUE TO	O (OR AS A CONSE	OUENCE (OF):	1	1				
disease or condition e. Due to (OR AS A CONSEQUENCE OF): Passable preumatica											
121	Sequentielly list conditions, if eny, leeding to immediate	DILE TO	0 (00 AC A DONOE)	audune e	D.ET.				,	16,4	
S	csuse. Enter UNDERLYING CAUSE (Disease or injury	· Mul	type ne	urol	egically	city	m	aslesen in	ceph	aletts	
트	that initiated evente	DUE TO	O (OR AS A CONSE	OUENCE (SP.			(in inj	ency		
CERTIFICATION	resulting in deeth) LAST	d									
	PART II. Other significant condition	ne contribution to	o deeth but not	regultine	in the underbil	on cause	alven in	Part I 24- une	AN AUTOPS	V 245 44	ERE AUTOPSY FINDINGS
DICAL	THE STATE OF THE S	- contributing to	o destil but not i	esuiting	in the dilderlyn	ig ceesa	Aiseil III		FORMED?	A	ALABLE PRIOR TO
ă								1 🗌 YE	S 2 40		F DEATH?
ME										1	☐ YES 2 ☐ HO
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CA					CERTAII	N 🗆 📗			
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	CE OF DE	OTHER:)	_				
S	1 Tes 2 Ano		☐ ER/Outpatient 3	DOA		ne 5 🗆 R	asidence	8 Other (Specify)			
표	27. MANNER OF DEATH	28e. DATE O (Month,	Day, Year)	28b. TH		JURY AT ORK?		28d. DESCRIBE HO	W INJURY C	CCURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation			_			NO	-			
	3 Suicide 8 Could not be		OF INJURY - At he	ome, farm,	atreet, factory, off	ce		281. LOCATION (Str. City or Town, S		ber or Rural Rou	te Number,
1	4 Homicide determined		, (-,,-,-					City of fown, 5	1010)		
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of	of my knowledge, de	eth occur	red at the time, da	and plan	end due	to the cause(e) end	manner as a	stated.	
M	(Check only one) 2 MEDICAL EXAMINE										nd menner ee stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIE								-		
BE	COUL STORAGO TO THE OF CERTIFIE	Look	- m)		29c. LIC	ENSE NUI	MBER	29d. D.	ATE SIGNED (M	100
2	30/NAME AND ADDRESS OF PERSON WE	IO COMPLETE	711	/	0.1.0	1 V	12	-814		1/13	170
	Real Topas	TO COMPLETED CA	USE OF DEATH (ITE		oler St		h		1-~	106	180
	Drad J WOO	yer In			HEL 2	+	II Vor	WOUL 1	10	، خرا	100
	31. DATE FILED (Month, Day, Year) JUL 1 4 199	32. DEGISTE	LUBLAC C	1 11				,			
	JUL 1 4 199	10 June	- HUNNESC-SC	The state							



Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Katie Smallwood JULY 1998 15 4:00 A.M. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CIVISTA MEDICAL CENTER LaPLATA CHARLES if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Deys 1 M 2 TF Yrs. Director 69 213-78-4162 Maryland March14,29 Usual Residence of Decedent ltem 27 is marked other than natural, or frems 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Prince Georges Brandywine 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 14949 Westwood Funerai U.S.A Road 20613 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after c Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural!. ~ Many Injury or other traumatic event. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: ð 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) Homemaker 12 Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Benjamine 2 Makle Maragret Savoy 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lloyd Smallwood / 5335 Holly St. Indian Head ,MD 20640 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cem. July 18,98 Clinton, Maryland 2060 Agresso Rd 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility 105 AdAms head on 20608 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finei disease or condition resulting in deeth) /Medical metastatic Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires thet the death certificete be executed attending physiclen end for use es the buriel-trensi Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) P.O. Box 68760, thet initieted events resulting in death) Lest Due to (or es e consequence of) ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records. by 2 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy page 2 s certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director, Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 24 hours efter death.

Funeral Director: After this letely filled in by the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Acciden 6 Could not be determined 3 Suicide 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a, Certifier Medicai within 24 hor To the Fune completely fi £ 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 4/2 D-47849 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 700 Old Line Center, Suite 100 Waldorf, Maryland 20602 Monika Lee, MD 31. Dete filed (Month, Day, Year) 32. Registre's Signature.

8 Julia Mullion Revolati State JULI 1998 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

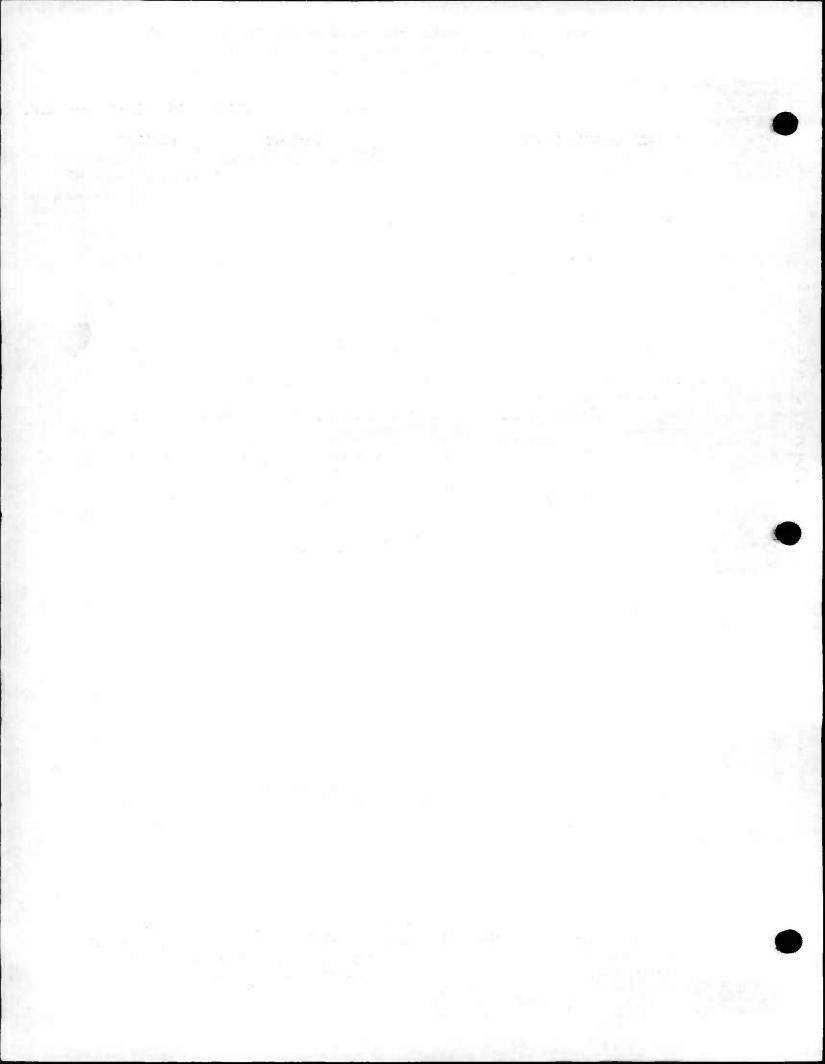
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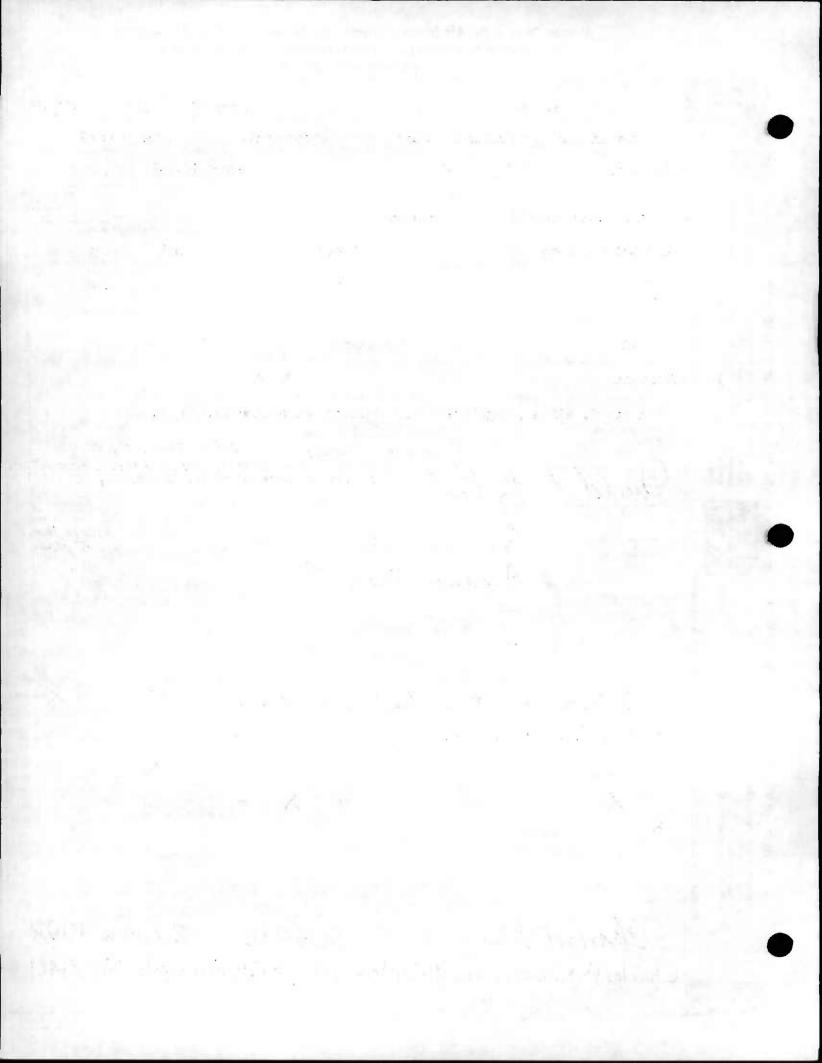
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Vee **Physician** 3:55 PM Louise Smith Stephenson June 19 1998 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Pleasent Living Convalescent Center Edgewater Anne Arundel If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months 1□ M 21XF Hours March 10,1901 Maryland Director 220-32-0584 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Directo Maryland | Anne Arundel Annapolis 10e Street and Number 10f. Zin Code 10g. Citizen of Whet Country? than "natural", or items 23s or the Medical Examiner must be 2625 Ogleton Road 21403 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married Specify: white 1□ Yes 2No Specify à 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Pages 1 and 2 should be filed within sent of Health and Menfal Hygiene. Elementery/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home I is marked other traumatic event, I 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Sam Smith Ida Sard 2 of Health and N Rem 27 is man cother traumet 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Elizabeth S. Allen (daughter) 2625 Ogleton Rd. Annapolis, MD 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Important: If it any injury or o Burial 2 Cramation 3 Removel from Stete 6/25/98 Seaboard, NC 4 ☐ Donetion 5 ☐ Other (Specify) Seaboard Cemetery 22. Nama and Address of Fecility John M. Taylor Funeral Home, Inc. e of Funeral S 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complication. that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** more than Immediete Ceuse (Final disease or condition resulting in deeth) /Medical domentia vears Examiner Due to (or es e consequence of): Examiner Cuseage sician end burial-transit heimer Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Lest Due to (or es e consequence of): requires that the death certificate be execu physician s the burial P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 98 attending for use es 23b. Dfd tobacco use contribute to the cause of death? been signed by the a should be deteched Pert fl. Other significant conditione contributing to deeth but not rasulting in the underlying cause given in Pert fl. 3 ☐ Probably 4 Unknown 1 Yes 2 No Records, þ 24b. Were autopsy findings evailable prior to completion of causa of death? 24a. Was en eutopsy performed? Completed artailure page 2 brillation 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica stely filled in by the funeral director, I 25. Vas case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 0 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel Injury 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homlcide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 29a. Certifier 🗷 Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. edicai 2 Medicat Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatuse and title of carpling 29c. Licensa number June unzu who completed cause of deeth (Item 23a) (Type, Print),

32. Registrer's Signature

Julia Davidson-Randall

Medical Pkwy#100, Annapolis,

State Registrar 31. Dete filed (Month, Day,

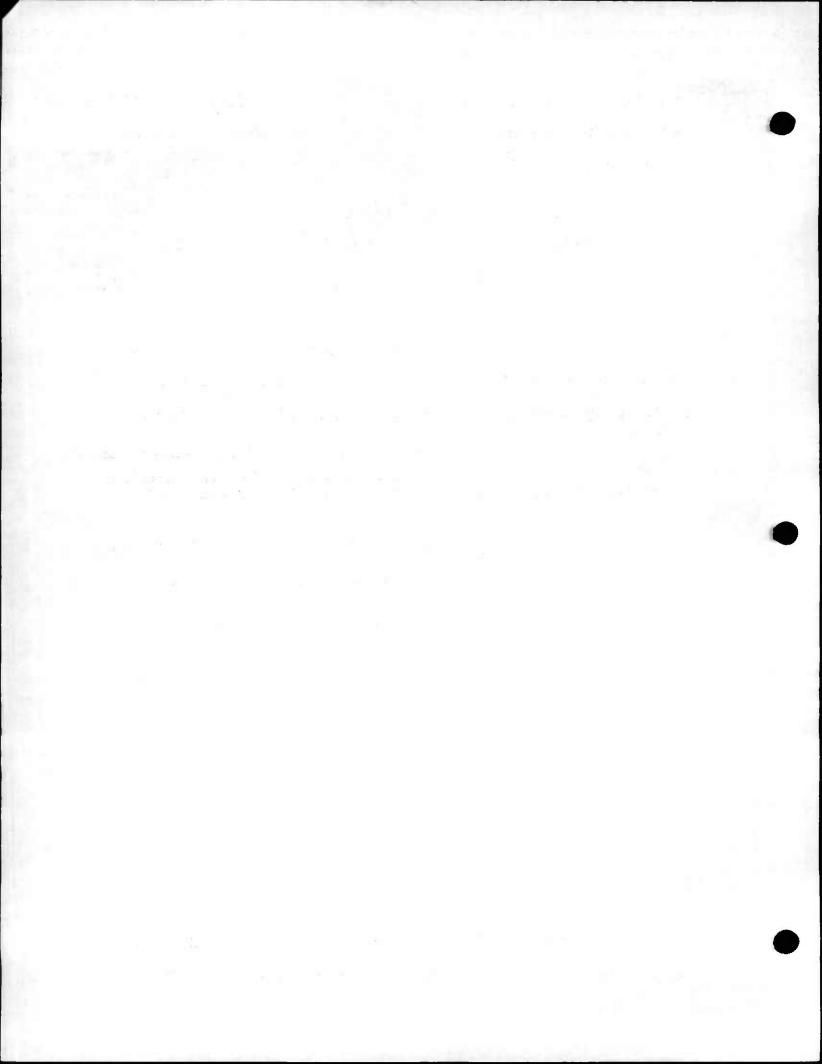


Fecility Neme (If not Institution, give AMHCS FORT HOLD Social Security Number 6. 5	we street end rumber) WARD DIVIS Sex 7. Age (Ir XXM 2D F 88 UNDEL S.W. 12. Was Decedent Ever Armed Forces? 1 (X ves. 2 D No. If 1 yes, Give Year or Dates: W ducation action action (1-4or S+) 0 (Type, Print) HEW Decedent Ever Armed Forces? 1 (X ves. 2 D No. If Yes, Give Year or Dates: W ducation action (1-4or S+) 0 (Type, Print) HEW Decedent Ever Armed Forces? 1 (X ves. 2 D No. If Yes, Give Year or Dates: W ducation action (1-4or S+) 0 (Type, Print) HEW	City, To Cit	wn or Location BURNIE 101. Zip Code 2106 13. Was Decedent of II Yes, specify Cu 1 Yes 2 No. a. Decedent's Usual Occ. (Give kind of work dom. iffe. DO NOT use ratin STEEL WORKE LLINGS b. Mailing Address (Street 17823 MARSHA of Disposition (Name of erry, crematory or other pictor) S MEMORIAL (22. Nama and Add SINGLETON 1 SECOND	I Hours Min. Hours Min. Hispanic Origin? (Staban, Mexican, Puents of Specify: upation to during most of worked) I B. Mother's Nam LOUISE et and Number or Ru LL MILL R. CEMETERY (Commerce) I FUNERAL AVE. S.W.	bocation of Deeth WARD 8. Date of Birth Month, Day, SEPT. 5, 11 Decity Yes or No-	Dey 20, 19 4c. County BAL 4c. County BAL 1910 Og. Citizen of V U.S.A 14. Race Specify 16b. Kind of Bu STEEL Maiden Surnam City or Town, PSTEAD, 20c. Location FALMOU' URNIE	of Deeth TIMOF 9. Birthpia a Countr VIRG 100 What Countr 1. a - American ck, White, et WHI usiness/Indu INDU: BEAG State, Zip C MD 2 City or Tow TH, VI MARYL	ace (State or Foreigny) INIA INIA ILLIANA ILLI
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Social Security Number 0.5 - 1.2 - 6.9.5 ual Residence of Decedent a. State 10b. County ARYLAND ANNE ARI a. Street and Number 203 SECOND AVE. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest pre Elementary/Secondary (0-12) 9 Father's Name (First, Middle, Last) PETER a. Informant's Name/Relationship (VERNON GREEN_NEP) b. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specificationship) Signature of Funeral Service Liber April 1. Enter the disease, or compook, or heert feliure. List only	Sex XXM 2 F 7. Age (fr 8 8 8 10 10 10 10 10 10 10 10 10 10 10 10 10	City, To Cit	wn or Location BURNIE 101. Zip Code 2106 13. Was Decedent of II Yes, specify Cu 1 Yes 2 No. a. Decedent's Usual Occ. (Give kind of work donning. Do NOT use ration of the Do NoT use ration of t	If Under 24 Hrs. Hours Min. Hours Min. Hours Min. If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most of worked) If Hispanic Origin? (St. ban, Mexican, Puertic or Specify: Upetion in during most or Specify: Upetion in during	8. Date of Birth (Month, Day, SEPT. 5, 1 Decity Yes or No- o Rican, etc.) king rel Route Number OAD, HAM, Date 5/24/98 HOME GLEN B	Og. Citizen of V U.S.A 14. Race Specify 16b. Kind of Bu STEEL Maiden Surnam City or Town, PSTEAD, 20c. Location FALMOUS	9. Birthpia Countr VIRG 100 What Countr e - Americar ck, White, et WHI usiness/Indu INDU: BEAGI State, Zip C MD 2 City or Tow TH, VI	ace (State or Foreigny) INIA INIA IL Inside City Limits 1 Yes 2 No. INIA IL INIA I
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State of Maryland / Department of Health and Mental Hygiene Amend #18, 7/21/98, BMW, Montg. Co. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month Des Yee **Physician** 16, 1998 6:55 AM ARLYN DUER STEWART JULY /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SILVER SPRING MONTGOMERY 10605 SHADY CIR. If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Day, Year) CT. 7, 19 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. **Funeral** Months Hours Deys 1⊠M 2□ F 1918 CALIFORNIA Director 545-09-9202 OCT. Usual Residence of Deceden with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director SILVER SPRING MD. MONTGOMERY 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 10605 SHADY CIR. 20903 U.S.A. Funeral 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry parmit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than "n any fijury or other traumatic event, in a Med Bhots. Elementery/Secondary (0-12) College (1-4or 5+) PSYCHOLOGIST PRIVATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Golda Be CHESTER FLOYD STEWART 2 HELEN 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) DORIS HELEN STEWART/WIFE SAME AS TTEM 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/17/98 CHAMBERS CREMATORY RIVERDALE. MD. 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner the attanding physician and hed for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of) P.O. Box 68760. Due to (or es a consequence of) resulting in deeth) Lest Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed by Division of Vital Records, by 9 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Was en eutopsy peen s certificate has b EDINO 1 Yes 2210 1 Tes the Hospital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes ZX No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Director: After this d in by the funeral 27. Menner of Death 1 A Vaturel Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) aftar 4 Homicide To the Hospital or within 24 hours af To the Funeral DI completaly filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. edicai 29a. Certifier one) 29d. Date signed (Month, Dey, Year) 29b. Signatur end title of certifier 29c. License number JULY 16, 1998 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 20903 CROMWELL, M.D. 831 UNIVERSITY BLVD. EAST, SUITE 37, DAVID SILVER SPRING, MD. 31. Date filed (Month, Day, Year) 32. Registrer Signature State

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** July 1998 Richard Insley Sutton 10:15 AM /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** 6805 Stonewood Terrace Rockville Montgomery If Undar 24 Hrs. 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) **Funeral** Days Months 1 ₩ 2 □ F Vrs 81 Director 513-01-6567 July 31, 1916 Kansas Usual Rasidance of Dacedant the Meryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Tyas 2 1 No Director Montgomery Rockville 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? parmit. Pages 1 and 2 should be filed within 72 hours after deeth v. Department of Health end Mentel Hysiene. Important: If item 27 is marked other than "natural", or items 23s any houry or other traumatic event, the Market 6805 Stonewood Terrace 20852 Funeral USA 12. Was Decadant Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indien, Black, Whita, atc. 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: þ Specify: White 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grada complated) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Flementery/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Federal Government 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Martha Evangeline Insley John Sutton 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Route Number, City or Town, Steta, Zip Coda) 9524 Wandering Way, Columbia, MD 21045 Sally S. Higgins (daughter) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ₺ Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 7/16/98 Rockville, MD 22. Nama and Addrass of Facility Francis J. Collins Funeral 21. Signature of Funeral Servige Lice Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

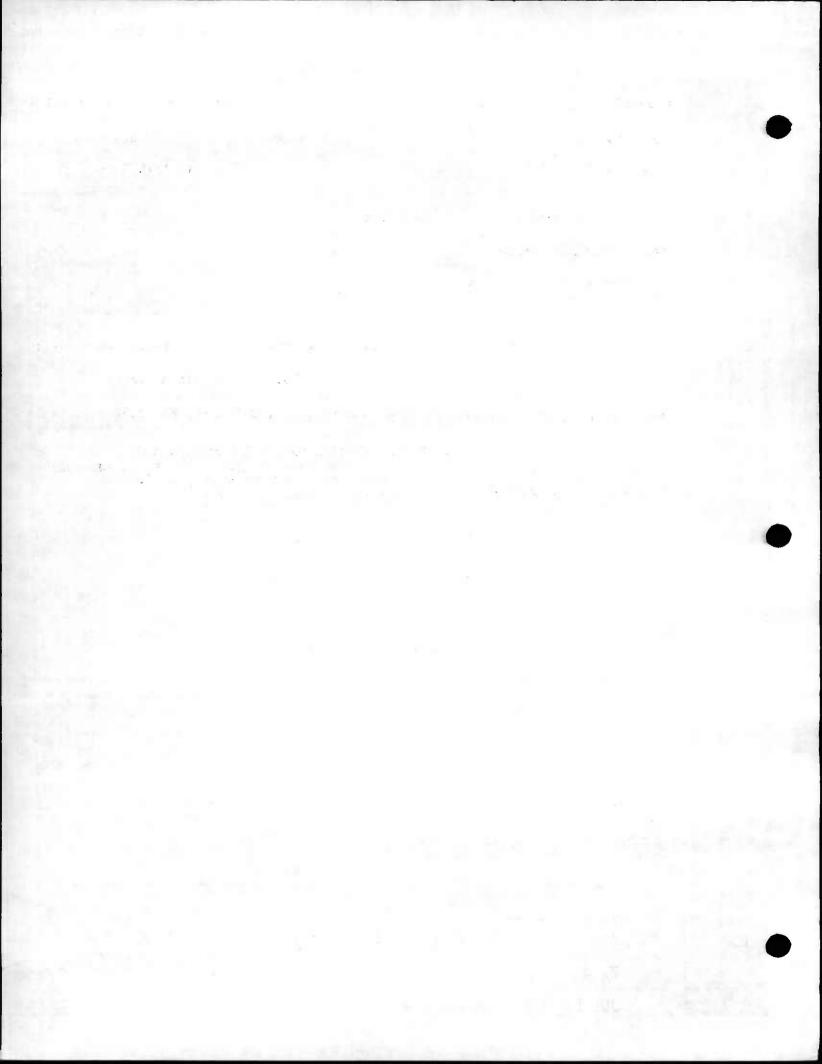
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one ceuse on each line. Silver Spring, MD 20901 Approximeta Interval Batween Onset end Death **Physician** Immediata Causa (Finat disaasa or condition resulting in daath) /Medical cardiac unnest Examiner Due to (or as a consequance of): Physician/Medical Examiner ABDOMINAL AONTIC Anenysme attending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In daath) Last Due to (or as e consequence of): P.O. Box 68760. Hyjset Fension

Due to (or es e consaquanca of): Prostatic euncet. signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 28 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wara autopsy findings available prior to completion of cause of death? been si Completed 24a. Wes an autopsy this certificate has rel director, page 2 1 ☐ Yas 2月No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours efter death.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. Medicai 29d. Data signed (Month, Day, Yaar) 29b. Signature and title of certifier 29c. Licansa numbar 15 30. Nama end eddress of parson who completed cause of death (Itam 23a) (Type, Print) Irene G. Tamagna, M.D. YCUT AUC Chevy C 31. Data filad (Month, Day, Year) 32. Registrer's Signature State JUL 1 3 1998 Schie Davidson-Randell Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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pletaly filled in by the funeral director, page 2 should be detached for use as the bur edical Certification: To Be Completed by Physician/Medical	25 27 29 29	5. Was cesa referre axaminar? 1 Yas 2 1 2 1 2 2 Accidant 3 Suicida 4 Homicida 9a. Cartifier (Check only one) 9b. Signetura and the suicida and addra	ad to medical No 5 Panding Invastigatio 6 Could not b datarminad 1 Certifying Ph Medical Examitation of the certifian in the certifiant in the	Hospital: 1 In Inc. 28a. Data of (Month, 28a. Place or building ayalclan: To tha baniner: On the bas and manna	Dua to (Dua to (Dua to (th but not ran patiant 2 [Injury Day Year) Injury - At h atc. (Space est of my kn is of axamin r stated.	DER/Outpatier 28b. Tima o Injury noma, farm, str	quance of): quanc	Other Work of the time of time of time of the time of	26. Placa of Dar: 4□ Nursing at ?? ras 2□ No a, data and pla pinion, daath oc	24a Daath (Check g Homa 5 28d. Das 28f. Loce City ace, and dua 1	1 ☐ Yas Was an parform 1 ☐ Yas only ona Rasidar cribe how tion (Strror Town, to tha caltima, da 29	autopsy lad? s 2X No l) noce 6 □ Oth w injury occur aat and Numb Stata) usa(s) and muta and place,	24b. Was every correct of control of the correct of	irra autopiliable prinpletion death?] Yas I Route if atad. the cau	sy finding ior to of ceusa 2☐ No

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician LILLIAN T. SCHUGAR JULY 11 1998 1005 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12-08-13 Birthplace (State or Foreign Country)
 POLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 84 Yrs. Director 065-05-0672 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Llmits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Exercines must be notified at 1 ☐ Yes 2 No Directo PALM BEACH BOCA RATON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8511 Casa del Lago 33433 USA permit. Pages 1 and 2 should be filed within 72 hours eftar death v Department of Health end Mental Hygiene. Important: If from 27 is marked other than "natural", or froms 234 any injury or other traumatic event, "The Healtest Exercisinal natural." Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Biack, White, etc. 1 ☐ Yes ②OXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes No Specify: WHITE by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JENNY UNKNOWN BERNARD THUN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DR. BERNARD BARRY SCHUGAR /son 256 POINCIANA ISLAND DR. NORTH MIAMI BEACH, £1 33160 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) al from State KING DAVID MEMORIAL GDNS 7-13-98 FALLS CHURCH, VA and Sefferal Ser ice Licens 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC. the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest. MD 20852 approximate lailure. List only one cause on each line. 23a. Part Enter the shock or hear Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CEREBROVASCULAR ACCIDENT 24 HOURS Examiner Due to (or as a consequence of): ACUTE RENAL FAILURE Physician/Medical Examiner 48 HOURS attending physician end for use as the burial-transit The law requiras that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 45 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy r this cartificeta has 2 No 1 ☐ Yes 1 TYes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 the Inpatient 2 I ER/Outpatient 3 I DOA 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1xt Naturel 2 Accident 2 🗆 No 1 Yes 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by th 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical 29a. Certifier

Division of Vital Records, P.O. Box 68760,

illian Schugar 10:05 Am

30

31. Date filed (Month, Day, Year)

JUL 1 3 1998

29c. License number

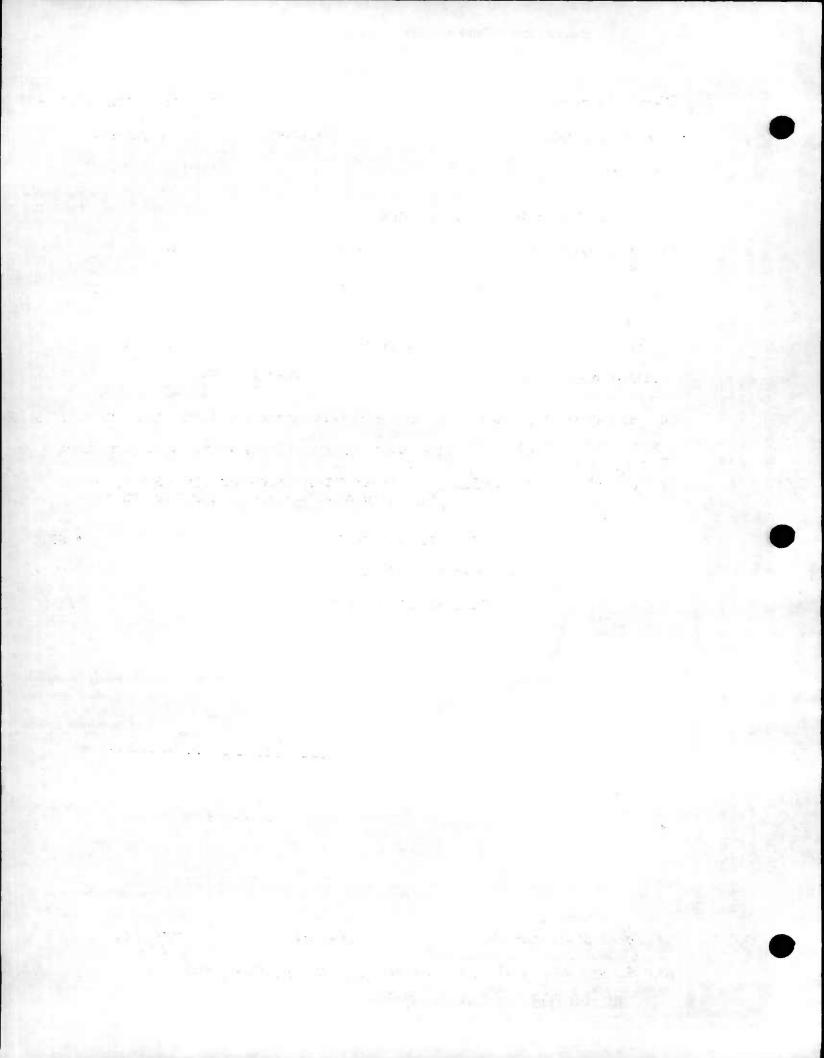
29d. Date signed (Month, Dey, Year)

29b. Signature and title of certifier Men a- Veydich

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 6410 ROCKLEBEE OR. BETHESDA, MO YURI A- DEYLUAK

State Registrar 32 Registrar's Signeture Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death July Y **Physician** 1145 4a. Facility Nama (Chot institution, give street and number) 1998 /Medical 4c. County of Deat 4b. City, Town, or Location of Daath Examiner Godhersburg 14 Brighton Mon OMCY4 if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 11/23/1915 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) **Funeral** 123M 2□ F Months Deys 82 Director 162-12-4328 Pennsylvania Usuel Rasidenca of Decedant Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Heelth end Mentel Hygiene.
Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits other treumetic event, the Medical Examiner must be notified at Montgomery Director 15 Yas 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 14 Brighton Court 20877 U.S.A. Funeral 12. Wes Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 X Yas 2 No if Yes, Giva 1953 − Yaar or Datas: 195 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: White by Specify: 3 ☐ Widowed 4 ☐ Divorced 1955 Completed 15. Decedant's Education (Spacify only highest greda complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collage (1-4or 5+) Medical Doctor Medicine 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Forrest Shaffer Jenny Williams 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 s Department of Heelth or Important: If Item 27 is any Injury or other treu once. Delilah Shaffer/Wife 14 Brighton Ct. Gaithersburg, Maryland 20877 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Blooming Glen Mennonite Cem. 7/11/98 Blooming Glen, Pa. 22. Nama and Addrass of Facility DeVol Funeral Home 21. Signeture of Euneral Service Licenses 10East Deer Park Drive, Gaithersburg, Md. 20877 Enter tha disaasa, or complications that causad tha daath. Do not entar tha moda of dying, such as cerdiac or raspiratory arrast, or haart failura. List only ona ceuse on eech line. Onsat and Death **Physician** immediata Ceuse (Final disaasa or condition resulting in daath) /Medical myocar dia Examiner Physician/Medicai Examiner oronary The law requires that the deeth certificate be axecuted the buriel-trans Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physiclen end for use es the buriel-trar that initiated avants rasulting in death) Last Dua to (or as a consequence of): Part Ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Rena q 24a. Was en eutopsy performed? 24b. Wara autopsy findings available prior to complation of causa of death? 2 X No certificete 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 26. Place of Deeth (Chack only ona)

Be Completed 2 Medical Certification:

Division of Vital Records, P.O. Box 68760,

25. Was cesa rafarred to medical axeminar?
112 Yas 2□ No 27. Manner of Daath 1 Naturel

5 Pending invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 4 Homicida

1 inpatiant 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Day Year) 28b. Tima of

28a. Plece of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Rasidance 6 Other (Spacify)

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signatura and titia of certifle

DMF Ker MO

29c. Licansa number D 00428

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) 2/0/ metcal Parlo INA W, BRECHER, NO DIME

Silver Spring,

State Registrar

5

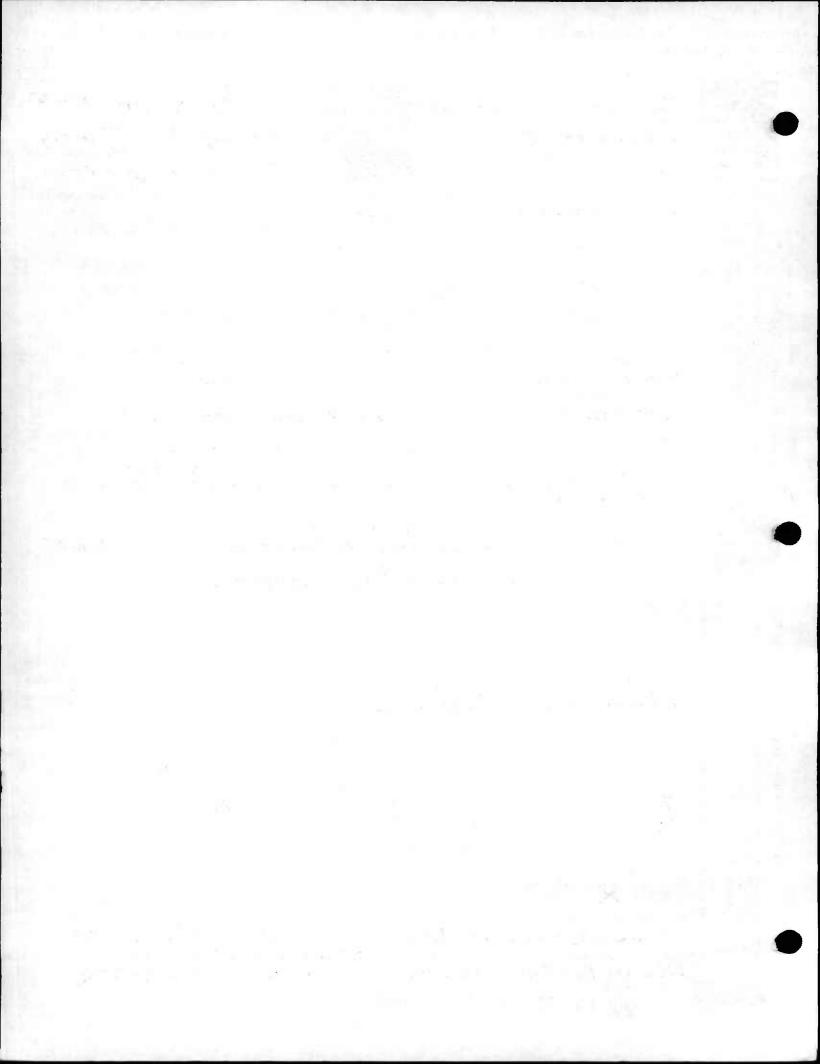
31. Data filad (Month, Day, Yaar)



s efter death.

I Director: After this or
of in by the funeral dire

To the Hospital o within 24 hours eff To the Funeral DI pompletely filled in



Months

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 2. Data of Daath

Clinton

Hours

If Undar 1 Yaar | If Undar 24 Hrs

Deys

	ľ
Physician	
/Medical	ı
	ľ
Examiner	ı

Director

Funeral

à

Completed

Be

1. Decedant's Nama (First, Middla, Last) Dorothy A. Sherr

Day Month July 14. 1998 3. Time of Death 4:30 a.m.

4a Facility Nama (If not institution, giva street and number) Southern Maryland Hospital

4b. City, Town, or Location of Death

4c. County of Death

Funeral Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or thems 23a application or other traumatic event, the Medical E.

Physician /Medical

Examiner

attending physician and for use as the burial-transit

signed by the a

cate has been significant category.

r this certificate baral director, page

After

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completaly filled in by the fu

Hospital or Attending Physician:

death.

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

þ

Completed

Be

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Certification:

edical

Baltimore, Maryland 21215-0020

with the Maryland

Usual Rasidance of Decedant 10a. State 10b. County

10c. City. Town or Location

Yrs

7. Aga (In yrs. last birthday)

8. Data of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) Nov. 21, 1904 Jersey City, NJ

Prince George

N/A

5. Social Sacurity Number

578-66-9061

N/A

Washington, D.C.

10d. Insida City Limits 1 XYas 2 No

10e. Street and Number

10f. Zip Code 20008

10g. Citizen of What Country?

U.S.A.

3801 Connecticut Avenue N.W., #518

12. Was Dacedant Evar in U,S. Armed Forcas?

93

13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.)

 Race - American Indian, Black, Whita, etc. Specify: White

1 Navar Married 2 Married 3 Widowed 4 Divorced

1 ☐ Yas 2 🕱 No If Yas, Giva Yaar or Datas:

College (1-4or 5+)

16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired)

1 Yes 2 No Specify:

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highast grada complated) Elamentary/Secondary (0-12) 12

Export Import Bank

17. Fathar's Nama (First, Middla, Last)

Civil Servant

18. Mothar's Nama (First, Middla, Maidan Sumama)

Alonzo Wemple McCathran

19a. Informant's Name/Relationship (Type, Print) niece 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 7614 Eaglet Court, Ft. Myers Florida 33912

Lila Anderson

Nancy Grigsby 20a. Mathod of Disposition

1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata

20b. Place of Disposition (Nama of cematery, cramatory or other place) Mount Comfort Crematory

20c, Location - City or Town, Stata 7/24/98 Alexandria, VA

4 ☐ Donation \$ ☐ Othar (Specify)

21. Signature of Fareral Service License eters Loh

22. Nama and Addrass of Facility
Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue NW, Washington, D.C. 20016

on her the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Dua to (or as a consaguance of)

Approximata intarval Batwaan Onset and Death 24 445

Immediate Cause (Final disaasa or condition rasulting in death)

Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseese or injury that initiated avants resulting in daath) Last

Dua to (or as a consequence of)

art II. C	Othar	significent	conditions	contributing to	death bu	ut not rasu	ulting In tha	undariying	ceusa giv	an in Pan

23t	Did tobac	co uee co	ntributa to tha	cause of death?
	1 🗆 Yes	2 No	3 Probably	4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to complation of ceusa of daath?

1 Yas 2 No 1 ☐ Yas 2 ☐ No

25. Was cesa rafarrad to medical axaminer? 1 Yes 2 No

5 Pending invastigation

6 Could not be determined

1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Dey Year) 28b. Tima of

Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28c. Injury et Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Dascribe how injury occurred

29a. Certifier

27. Mennar of Death

1 Natural

2 Accidant 3 Suicida

4 T Homicida

15 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data end place, and dua to tha causa(s) and mannar es stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier

29c. Licansa number

29d. Data signad (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of parson who completed ceuse of death (Item 23e) (Type, Print)

Variables

- IANNE 47 1, our 31. Data filad (Month, Day, Year)

Livingson Road Such #101 Ft. WKK. M.D 11701

26. Placa of Daath (Chack only ona)

State Registrar

JUL 1 7 1998

32. Registrar's Signatura Alie Devidson

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 4b. City, Town, or Location of Death 4c. County of Deeth ELLEN Y. SHIN /Medical 6:55AM 4a. Facility Nema (If not institution, giva straat and number) Examiner 12416 Bacall Lane Potomac Montgomery If Undar 1 Year | If Undar 24 Hrs. 5. Sociel Sacurity Number 6. Sax 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□XF Months Days Hours Min. Yrs. Director 53 215-72-6794 10/18/1944 Korea death with the Maryland 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Modical Examiner must be notified at Director MD 1 ☐ Yas 2 No Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12416 Bacall Lane 20854 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 11. Maritel Status 14. Race - American Indian permit. Pages 1 end 2 should be filed within 72 hours after. Department of Heelth end Mental Hygiene. Important: If Item 27 is merked other than "natural; or the any injury or other traumatic event. Its services. Bleck, White, etc. 1 ☐ Yes 2 📉 No If Yas, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Korean ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Cosmetologist Owner/Cosmetic 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Sumema) Be 2 Jungkwon Kim Unknown 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jin H. Shin 12416 Bacall lane Potomac, MD 20854 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crametory or other plece) Date 20c. Location - City or Town, Stata N Burlal 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 7/13/98 Onley, Maryland 21. Signature of Fungral Service Lig 22. Name end Address of Fecility Brus Murphy Falls Church Funeral Home 04 Falls Church, Virginia
Falls church, Virginia
Falls church, Virginia
Falls church, Virginia
Falls church, Virginia Approximete Intervel Between Onset end Deeth Physician etastan /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner ettending physician end for use as the burial-trensit law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Records, by Completed 24b. Were eutopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital I or Attending Physician: after death.
Director: After this certifica 25. Wes cese refarred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth Certification: 28b Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homlcide Hospital of 24 hours a
 Funeral D pelij 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and mannar stated. edicai 29e. Certifier

MIL

Ween Way

nd eddress of person who completed causa of death (Item 23a) (Type, Print)

RA CHAN M.D. 7 (7) 5 (7)

32. Registrar's Signeture

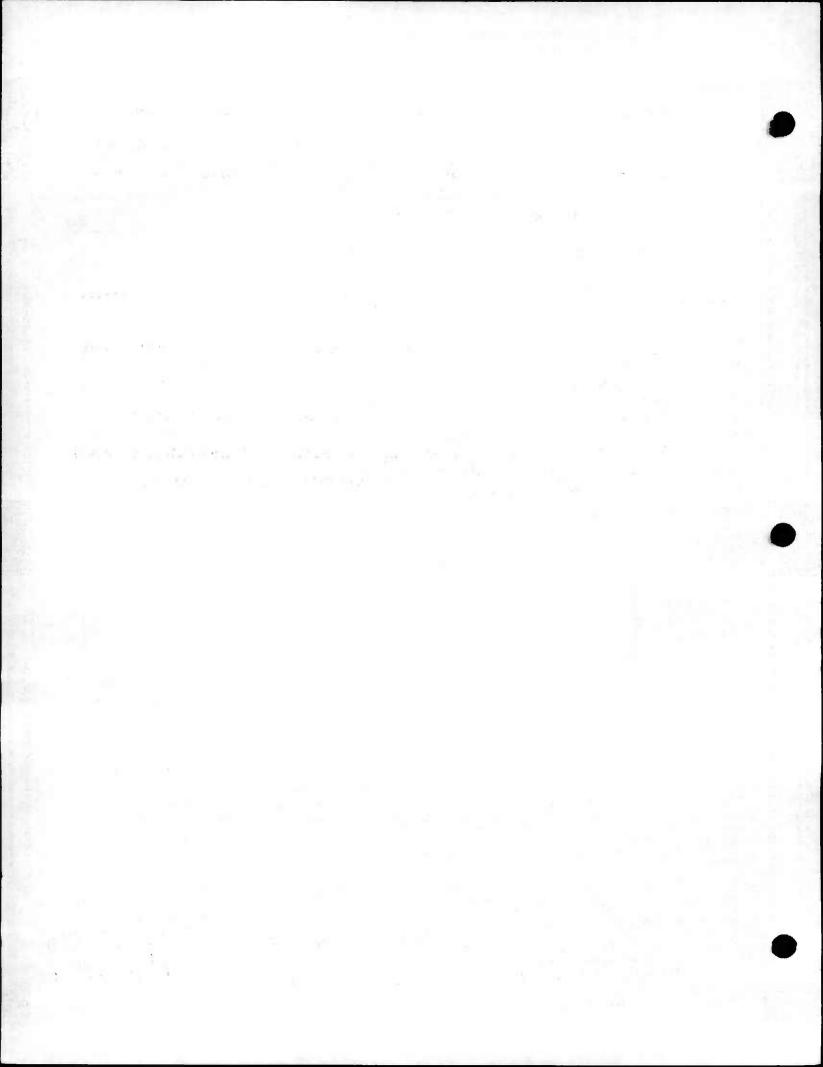
Julia Davidson

29d. Data signed (Month, Dey, Year)

State Registrar 29b. Signature and title of certifier

31. Dete filed (Month, Dey, Year)

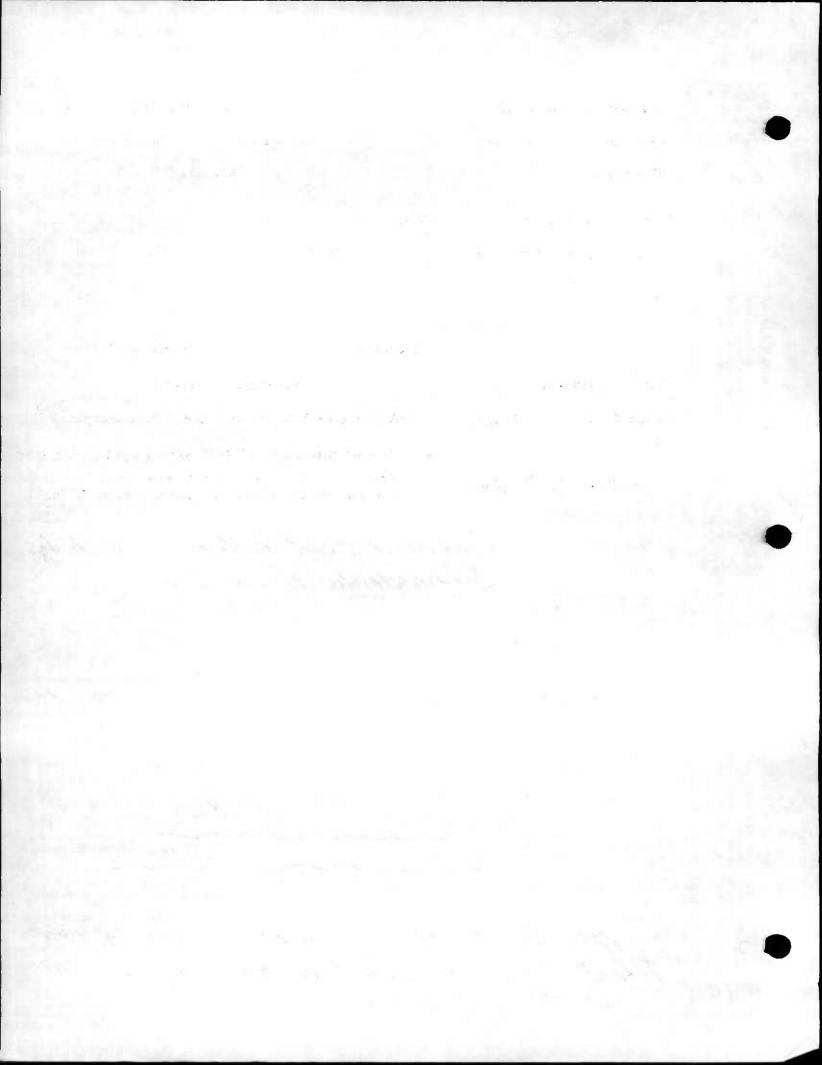
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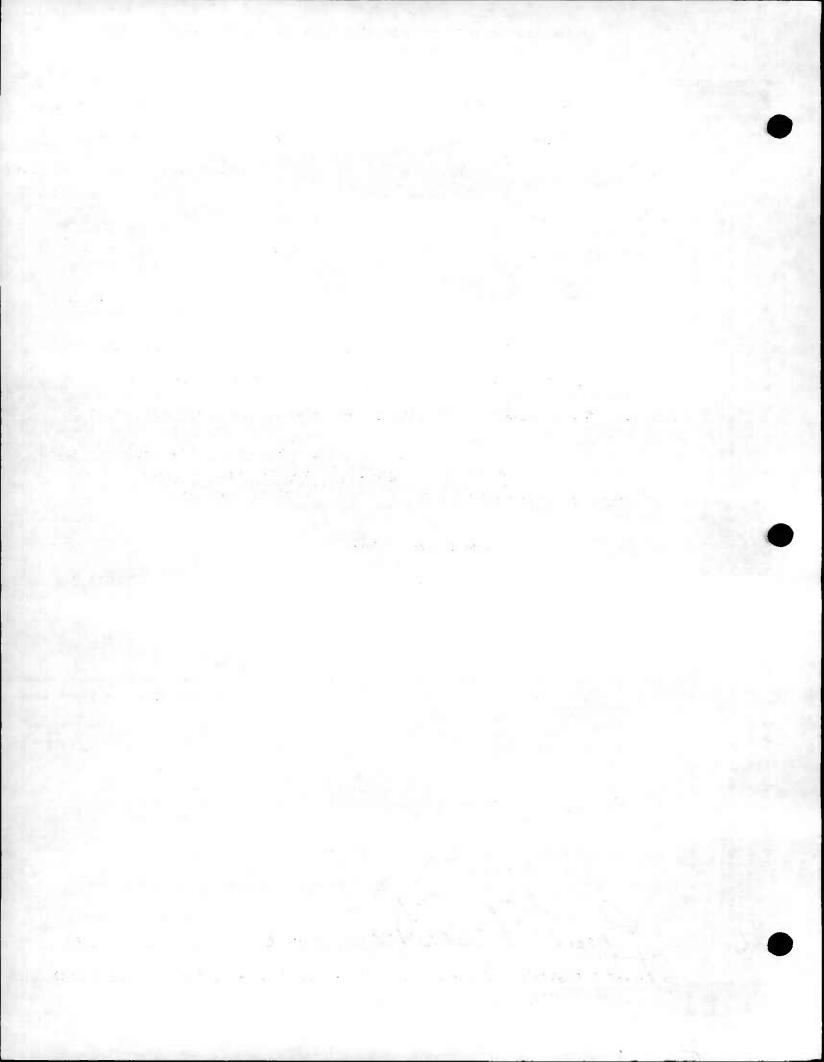
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Physic	Pert II. Other	Ignificent condit	lons contr	ributing to daat!	but not res	ulting in the u	nderlying c	ause giv	en in Part I.	- 130	23b. Did to	obacco use co	ntributa to	the cause of de
돈											101	res 2X No	3 Prob	ably 4□ Unkr
d by				116							24a Was	an autopsy	24b. War	ra autopsy findin
											perfor	med?	com	ra autopsy findin ilable prior to apletion of cause
ete e											4.00	eTT is		aath? Yes 2□ No
mplete		referred to medic	al						Of Bless	of Dooth	(Check only o			162 20140
Pege 2	25 Was 2008			ospitel: 1 1 Inpa	atient 2	ER/Outpetie	nt 3 DC	Oth	Or.			ne) lance 6 □Oth	ar (Specify)
Be sctor	25. Was cesa examiner?			28e. Date of I		28b. Time o		28c. Injur Wor		- 1		ow injury occur		/
To Be	examiner? 1 Yas 27. Mannar of	2X No Death			Dey reer)	Injury	М		Yes 2□N	lo				
To Be	examiner?	2X No Death II 5 □ Pendi ant invest	tigation	(IMORIE),				***		2	of Landina /C	troot and Numl	ber or Rurel	Route Number,
in by the funeral director trification: To Be	examiner? 1 ☐ Yas 27. Mannar of 1 ☒ Natura	2X No Death I 5 □ Pendi ant invest de 6 □ Could	tigation	28e, Piece of	Injury - At h etc. <i>(Speci</i>	ome, ferm, st	reet, factory	y, office			City or Tow	m, State)		
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pletely filled in by the funeral director edical Certification: To Be	examiner? 1 Yas 27. Mannar of 1 Matura 2 Accid 3 Suicid 4 Homi 29a. Certifiar (Check or	2 No Death 1 5 Pendi ant invest 10 Certify 1 Certify 2 Medica	ing Physic in Examine	28e. Plece of building, clen: To the be	etc. (Special st of my known of examine stated)	owledge, deet totion end/or in	occurred vestigetion	et the tin , in my o	pinlon, deeti	I plece, e h occurre	City or Tow	eausa(s) and madata and placa,	and dua to	ated. the ceusa(s) Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month **Physician** 8+ Wilsie Virginia Townsend 0730 4b. City, Town, or Location of Death 1998 /Medical 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Dec 30, 1920 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Aga (In yrs. lest birthday) 0 **Funeral** Deys 1□M 2XF 219-07-9909 Yrs Director Usuel Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be nothed at 1 ☐ Yes 2 ☑ No Director Worcester Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6226 Basket Switch Rd. 21841 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yeer or Dates: 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indien. 11. Marital Status Black, Whita, atc. OWNSEND Pagas 1 and 2 should be filed within 72 hours aftar 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ Mo Specify: þ 3X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decadent's Education (Give kind of work done during most of working lifa. DO NOT usa retired) (Specify only highest grede completed) Elemantary/Secondary (0-12) College (1-4or 5+) Cook Nursing Home Maryland 18. Mother's Neme (First, Middle, Malden Surneme) 17. Fether's Neme (First, Middle, Last) Be and Mental Wilmer Powell 2 Rosie Price Powell > 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) Haalth 8 6226 Basket Switch Rd., Newark, MD 21841 Location (Name of Dete 20c. Location - City or Town, Stata Willie Mae Dallas/daughter itam 27 Baltimore, 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Department of H Important: If its any injury or ott once. 1 Burlel 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Wesley UMC Cemetery 7/11/98 | Snow Hill, MD 21. Signeture of Egneral Service Ligan 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter tha diseesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errast, shock, or haart failure. List only one causa on each lina. Approximete intarval Batween Onsat end Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Corehra Vascela Examiner Physician/Medical Examiner attending physician and for usa as the burial-transit The law requires that the death cartificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated avents resulting in death) Lest P.O. Box 68760. Due to (or es a consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à has been signal and a should be 24b. Were autopsy findings eveilable prior to complation of causa of deeth? 24a. Was an eutopsy performed? Completed paga 2 s 20 No 1 Yas 2 1 No 1 Tyes cartificata Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica ataly filled in by the funeral director, Be 25. Wes case refarred to madical 26. Pleca of Deeth (Check only one) exeminer? Hospital: Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) To the Hospital or Atterwithin 24 hours after das To the Funeral Director completely filled in by the 3 Suicide 28a. Place of Injury - At home, farm, streat, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to tha ceuse(s) end menner es stated. 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end pleca, end dua to the causa(s) and menner steted. 29a. Certifian edical

29c. License number

29d. Dete signed (Month, Dev. Year)

State Registrar

3

29b. Signature end title of certifier

31. Date filad (Month, Day, Year)

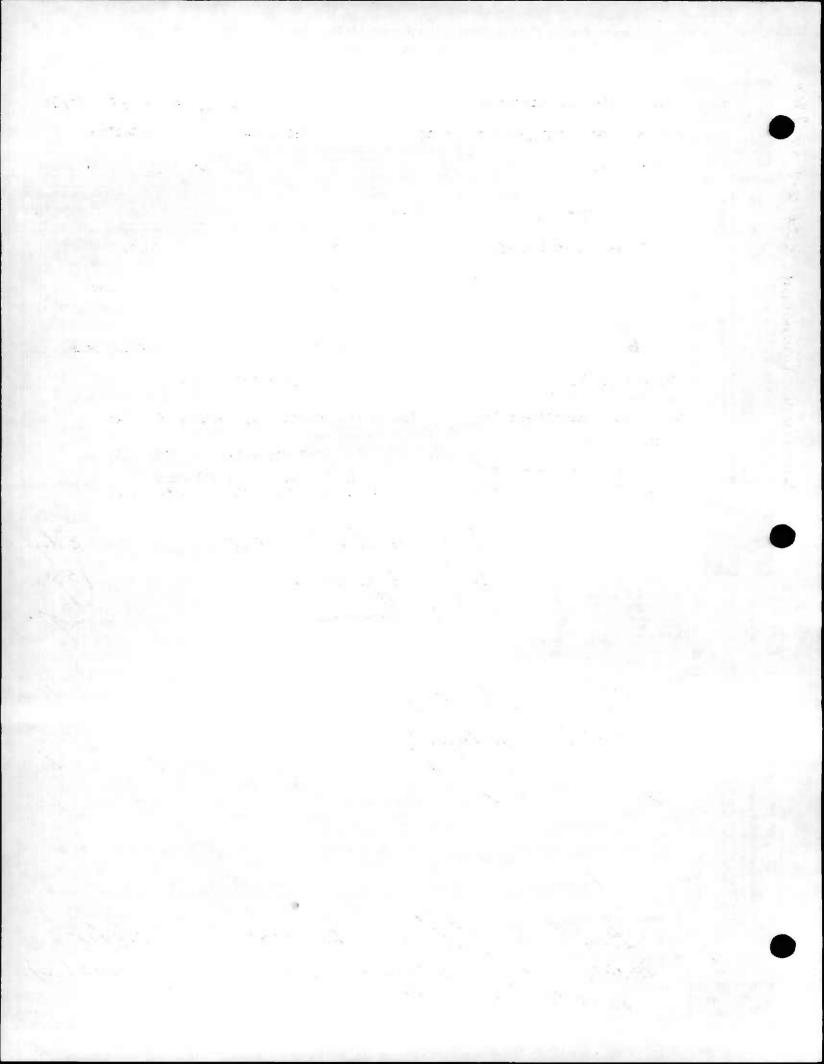
30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

C

32. Redistrer - Signature

5.

909



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** ANN VICTORIA THOMPSON 13 1998 July 9:12pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 912 If Under 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) M **Funeral** Months 85 **Director** 220-66-8810 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD Port Tobacco Director Charles 1 ☐ Yes 2X No 28a-1 10f. Zip Code 10g, Citizen of What Country? ŏ USA items 23a Warehouse Landing Rd. 20677 by Funeral 8320 deeth 12. Was Decadent Ever in U,S Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 PNo Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify American Specify: 3 ☐ Widowed 4 ☐ Divorcad Indian Completed permit. Peges 1 and 2 should be filed within 72 hr. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natur any highry or other traumatic event, if a Medical Otter." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be William Thompson Ellen Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Swann/Niece P.O. Box 103 Pomfret, MD 20675 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Ignatius Chapel Pt.7/16/98 Port Tobacco, MD 21. Signature of Funeral Service Licanses AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical Examiner Due to (or as a conse Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last buriel-tran physician the death certificete be the Due to (or as a con for use Part il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. detached 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 □ Probably Unknown signed t ð Should Completed 24b. Were autopsy findings aveileble prior to 24e. Was an autopsy performed? completion of cause of death? page 2 s 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 2

Vietoria this death. Ann 24 hours efter deat Funeral Director: filled in by

Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of De 28b. Time of 28d. Describa how injury occurred 1 Naturel
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

D - 20629

29a. Certifier (Check only one)	Oertifying Physicia 2 Medicat Examiner:	an: To the best of my know On the basis of examinetic	ledge, death occu on and/or investig	rred et the time, dete and plece, en etion, in my opinion, death occurred	d due to the ceuse(s) end menner es stated. d et the time, date and place, end due to the cause(s)
29b. Signature an	d title of cartifier.	1 an		29c License number	20d Date Linned (Month Day Year)

irson who completed cause of deeth (Item 23a) (Type, Print

111345 Pembrooke Square, Ste 103, Waldorf, Maryland 20603

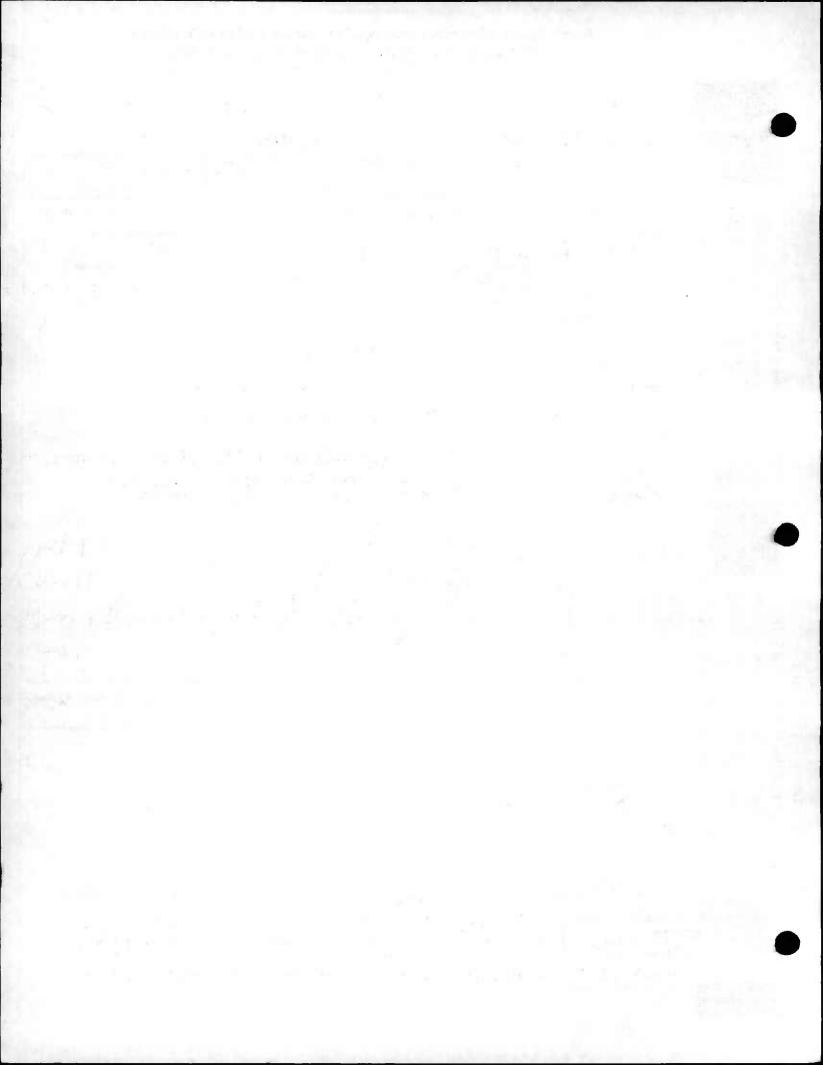
State Registrar

completely

within 2 ŝ

Certification:

Medical



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Dev Month Vaar Salvatore JULY 13 1998 06:10PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL

5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) Months Days 1⊠M 2□F Yrs. 578-38-1319 Jun. 4, 1925 Washington, D.C. Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 21 No Maryland | Montgomery Rockville 10f Zin Coda 10g Citizan of What Country? 10e. Street and Number 20852 USA 4733 Wyaconda Road 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarican Indian, Bleck, White, etc. 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: T. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify. 3 Widowad 4 Divorced White WW II 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Barber Beauty 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Trapani Salvatore Caterina DiMisa 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Constance Trapani Wife 4733 Wyaconda Road Rockville, Maryland 20852 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Cemetery 7/17/98 Brentwood, Maryland 21. Signature of Funeral Service Lic 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Part 1. Entar tha diffuse, or complications that causad the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, thock, or heart fall, fa. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Cause (Final disaasa or condition rasulting in daath) Sepsis 2 days Dua to (or as a consaquanca of): Neutropenia weeks Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Diseasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Acute months Leukemia Myelogenous Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings avellable prior to 24a. Wes an autopsy performed? complation of causa of daath? 2 X No 1 ☐ Yas 2 ☐ No

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Evarings must be notified at other.

Examiner

Physician/Medical

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Completed

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Certification:

25. Wes casa rafarrad to medical

1 ☐ Yas 2 No

27. Mannar of Death

Natural

2 Accidant

4 D Homicida

3 Suicida

29a. Cartifiar

physician end s the buriel-transit ettending p been signed by the should be deteched page 2 : certificate this

The lew requires that the death certificete be executed P.O. Box 68760, Division of Vital Records, Hospital or Attanding Physician: After efter death. Director: Aft filled in

To the Hosp within 24 ho To the Fune completely fi 341

24 hours e

Medicai

12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and menner es steted.
2 Medicat Examiner: On the basis of examination end/or invastigetion, in my opinion, daath occurred at tha tima, data and placa, and due to tha causa(s) and menner stated. (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number ende, MD RES-000 30. Nama and addrass of person who complated causa of death (item 23a) (Type, Print)

1 Inpatiant 2 □ ER/Outpatiant 3 □ DOA

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28b. Tima of

29d. Data signed (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)

Hospitai:

5 Panding investigation

6 Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

Street, Tower 110, Bastimore, Maryland North Wolfe 32. Ragistrar's Signatura

28c. Injury et Work?

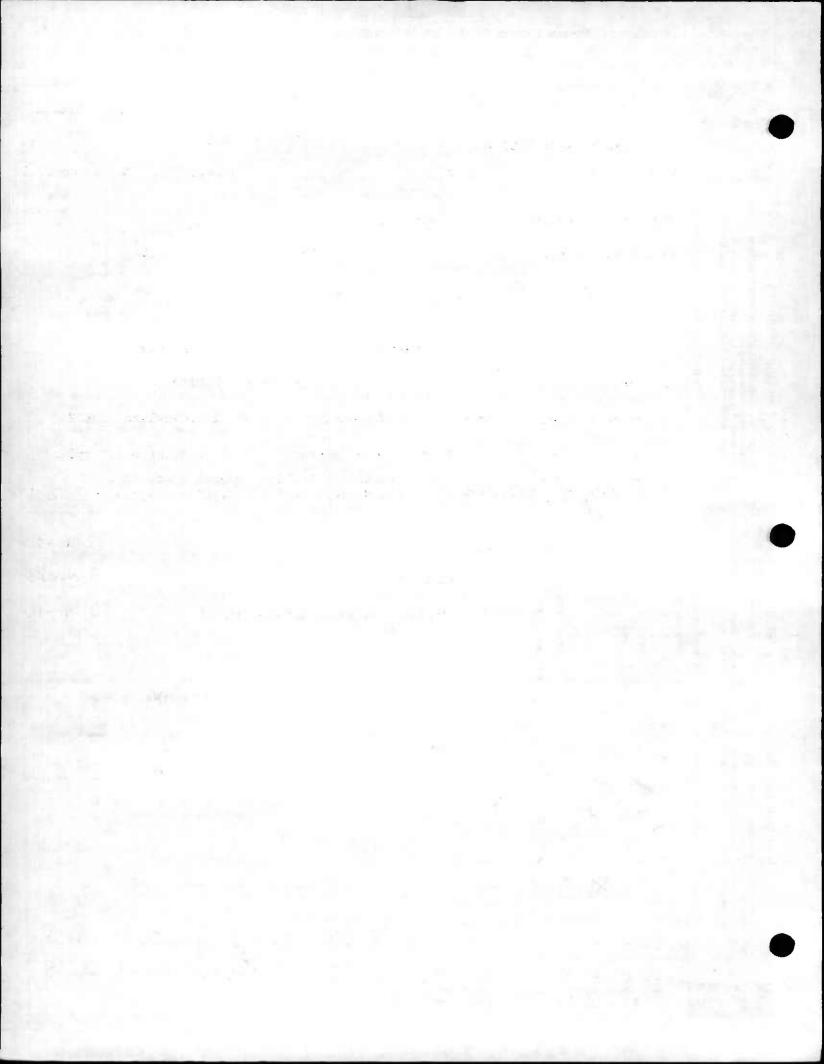
1 Yas 2 No

26. Placa of Daath (Chack only ona)

Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Spacify)

28d. Describe how Injury occurred

State Registrar



Please Type or Print in Biack indeiible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Month Year Linda Darlene Wolf July 9, 1998 6:00 AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State or Country) Nov. 28, 1946 California 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Days 1 □ M 2 🕅 E 51 214-48-4120 Yrs Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d, Insida City Limits 1 X Yas 2 □ No Frederick Maryland Frederick 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 21703 U.S.A. 5803 Hobblebush Court 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yas 2 전 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, Whita, atc. 1 Never Married 2 Married Specify: White 1 ☐ Yas 2 No Specify: 3 ☐ Widowad 4 ☐ Divorced 16a. Dacedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work done during most of working life. DO NOT usa ratired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) health care nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Helen V. Butts Barr W. Wolf 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 9504 Glade Ave. Walkersville, MD 21793 Sharon L. Kline/cousin 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 7/11/98 Wolfsville, MD Wolfsville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Hartzler Funeral Home 21. Signatura o Funaral Sarvice License 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused to math. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat end Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be

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10a. Stata

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner use as the bunal-transit signed by the attending physician and d be detached for use as the bunal-trar should be detached by Completed Be 2 filled in by the funeral Certification:

The law requires that the death certificate be axecuted

cartificate

After this

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

Attending Physician:

Division of Vital Records, P.O. Box 68760,

Immediate Causa (Final diseasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last

Due to (or as a consequence of)

eavs

Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Dld tobaçoo use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of causa of daath?

1 ☐ Yas 2 100 26. Placa of Daath (Check only one)

1 ☐ Yas 2 ☐ No

	Was cese		to medica
	axaminar?		
	1 Yas	2 No	

2 Accident

3 Suicida

29a. Cartifier

4 Homicida

27. Manner Death 1 Natural

5 Pending investigation 6 Could not be datarmined

1 Inpatiant

Hospital:

2 ER/Outpatient 3 DOA 28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Describe how Injury occurred

281. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura end titla of certifiar

28a. Place of Injury - At homa, farm, straat, factory, office building, afc. (Spacify)

29c. Licansa number

29d. Data signed (Month, Day, Yaar)

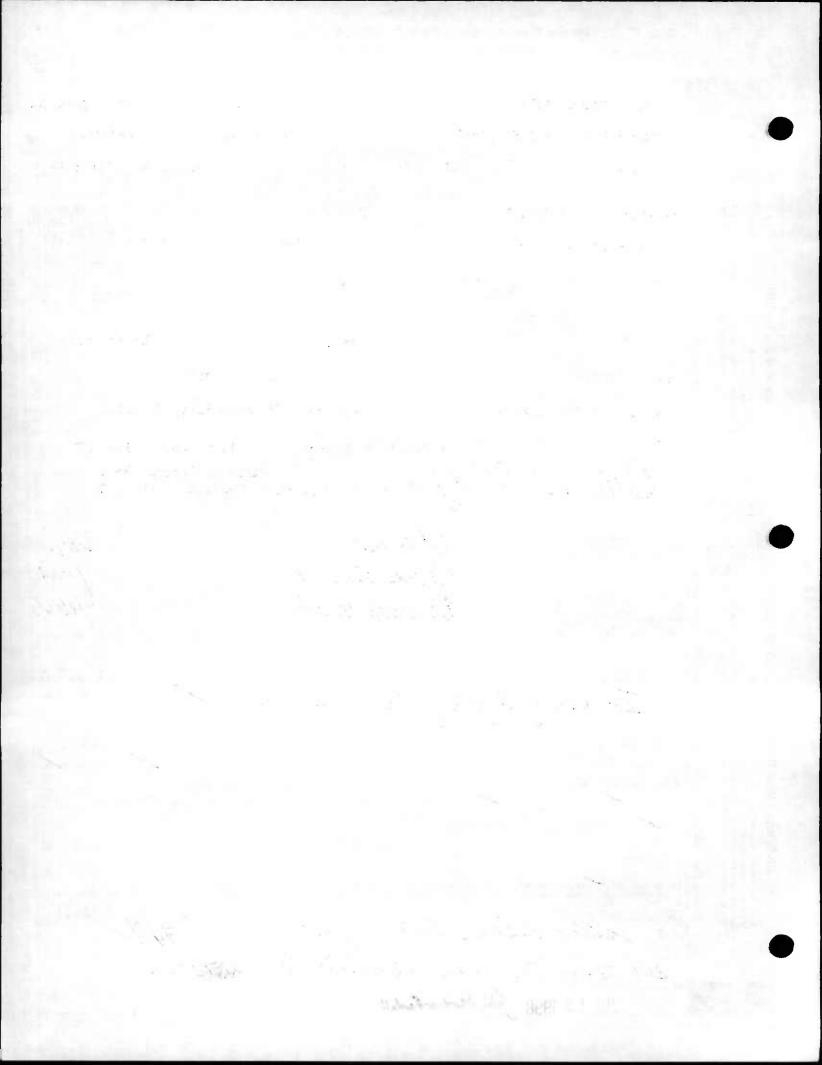
30. Nama end eddress of person who complated ceusa of daath (Itam 23a) (Type, Print) Mark P. Rubin 201 Thomas Johnson VR. Fr. 60 Erick Physics

State Registrar

Medical

31. Data filed (Month, Day, Yaar)

32 Ragistrar's Signatura Jaki Studenka



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath **Physician** EMILY AM WATKING Facility Name (If not Institution, giva street and number) /Medical 4b. City, Town, or Location of Death BACTIMORE CIT 4c. County of Deeth Examiner HOSPITA AUNES 8. Data of Birth (Month, Day, Year) If Undar 24 Hrs. 9. Birthplaca (Stata or Foraign Country) MARY AND 5. Social Sacurity Number If Undar 1 Yaar 6. Sax 7. Aga (In yrs. last birthday) Days Months 1 M 2 F NONE Usuat Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No CARROLL WestminsTER Directo MARYLAND 10f. Zip Coda 10a. Citizen of Whet Country? 10e. Street and Number U.S 21158 NDSOR Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Giva 14. Race - American Indian, Black, White, atc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 11 Marital Status 1 Nevar Married 2 Married 1□ Yas 2 No Specify. Specify: WhITE P 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) VONE INFANT 18. Mother's Nema (First, Middle, Maidan Sumama) 17. Fethar's Name (First, Middle, Last) e WATKINS TIMOTHY JISA SMITH 2 MHOL 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) DESTMINSTER, Mel 21158 WINDSOR JOHO TIMOTHY WATKING FATHER Dn. 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State 20b. Place of Disposition (Nama of cemetery, crametery or other place) Data KRIDERS CEMETERY 7-14 WESTMOSER 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Euperal Service Licenses 22. Name and Addrass of Facility 21157 日、一 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haar failure. List only one ceusa on each line. Approximata Intarval Batwaan Onsat and Daath Immediate Cause (Final HOURS disaase or condition resulting in death) Dua to (or as a consaquance of) Examiner Sequantially list conditions, if any, laading to immadiate ceuse. Enter Underlying Causa (Disaasa or Injury that Initiated events rasulting in deeth) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dld tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to completion of ceuse of death? Completed 24a. Wes an autopsy 2 100 1 ☐ Yas 2 ☐ No 1 Yas Be 25. Was casa rafarred to medice! 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

Physician /Medical Examiner

Funeral

Director

worde

ed other than "natural", or items 23s or 28s-f shows event, the Medical Exercities must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer constraint of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or item any injury or other traumatic event, the page.

with the Maryland

ettending physician end for use es the buriel-transit ed by the e signed by should be

The law requires thet the death certificate be executed this certificate After this certifical funeral director, p or Attending Physician: death. Director: within 24 hours aft To the Funeral DI completely filled in

Emily (baby Girl) WAtkin

State Registrar

edical

1 Naturel

2 Accidant

3 Suicida

29a. Cartifian (Check only one)

4 Homicide

29b. Signature and title of certifier

Deen artwort

5 Panding

Investigation

6 Could not be determined

29c. Licansa number

1 Yas 2 No

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

30. Nema end eddress of person who complated ceusa of death (Itam 23a) (Type, Print)

ST AGNES HOSPITHL

BAUTIMORE,

32. Registrar's Signatura 31. Data filad (Month, Day, Year) JUL 1 4 1998 Talix other Redall

28e. Piece of Injury - At home, farm, street, factory, office building, atc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Jeiss Gilbert 998 705 08 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE if Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) May 3, 1915 9. Birthplece (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months X X M 2□ F Deys Yrs 83 066-03-7735 Usual Rasidance of Dacedant 10a. State 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 Yes 2 □ No Maryland Montgomery Potomac 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 10500 Democracy Lane 20854 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Dates: 14. Race - American Indien, 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1□ Yas 2☐No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Naval Air System College (1-4or 5+) Elementery/Secondary (0-12) Command Aeronautical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hannah Ehrlich Benjamin Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, Stata, Zip Coda) 10500 Democracy Lane Potomac, MD 20854 Pearl Weiss/Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Data 1 □ Burial 2 □ Cremetion 3 □ Ramoval from State 4 ☐Donation 5 ☐ Othar (Specify) 7/12/98 Falls Church, VA King David Mem. Gdns. 22. Name end Address of Fecility Ives-Pearson Funeral Home 21: Signature of Funeral Service Licensee 2847 Wilson Blvd. Arlington, VA 22201 selace a 23a. Part1. Enter the disance or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or haert failure. List only ona causa of aech lina. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition rasulting in daath) month carcimomo Due to (or es e consequence of): Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceusa (Disaasa or injury Due to (or es e consequenca of) that initiated events resulting in deeth) Lest Due to (or as e consequança of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatiant Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1 Yes 2 No 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work?

Physician /Medical Examiner Physician/Medical Examiner

Physician

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Itam 27 la marked othe any linjury or other traumatic event page.

Baltimore, Maryland 21215-0020

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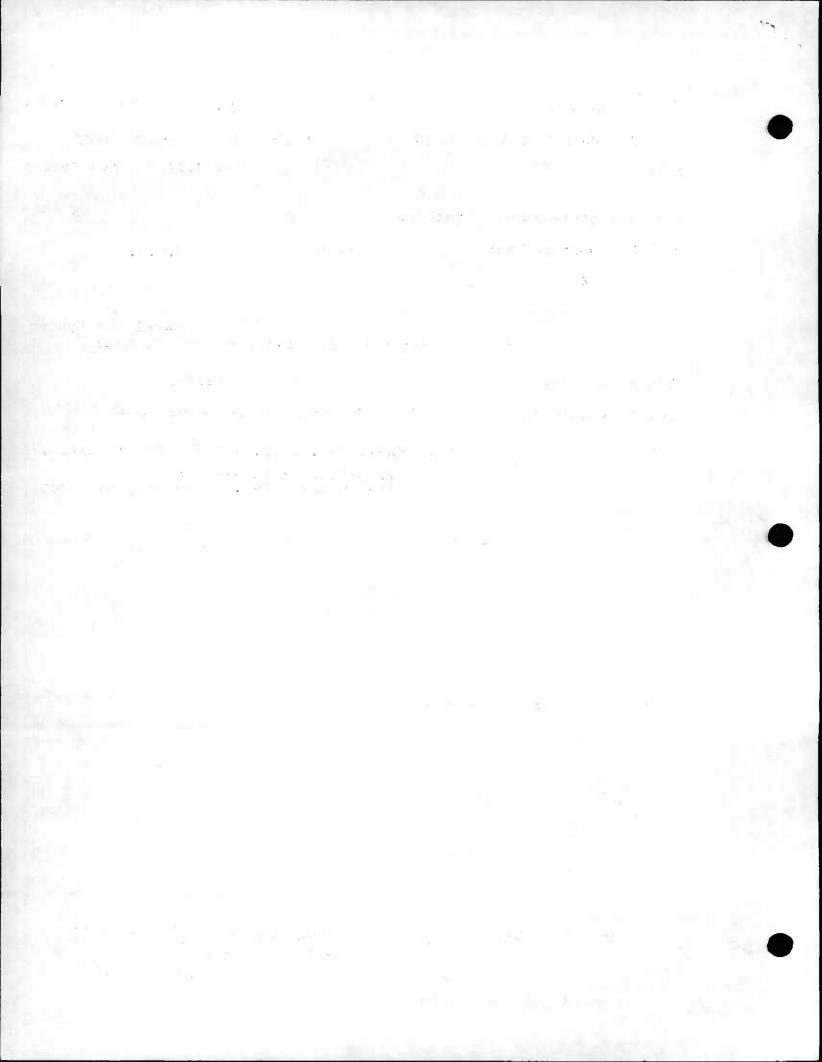
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The law requires that the death certificeta be axecuted peen certificata or Attanding Physician: funeral director, this After ue Hospital or Attanding n 24 hours efter death. filled in by within 2 To the

Division of Vital Records, P.O. Box 68760,

1 ☐ Yes 2 ☐ No 2 Accident invastigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, ferm, streat, factory, offica building, atc. (Spacify) 4 ☐ Homicida 29a. Certifier 1 🗹 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 308 SOTOSIMD GEOTZGE 30. Neme end eddress of person who complated causa of death (Item 23e) (Type, Print) Medical Center # 300 Drive 31. Data filed (Month, Day, Year) 32. Registrar's Signatures JUL 1 4 1998

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

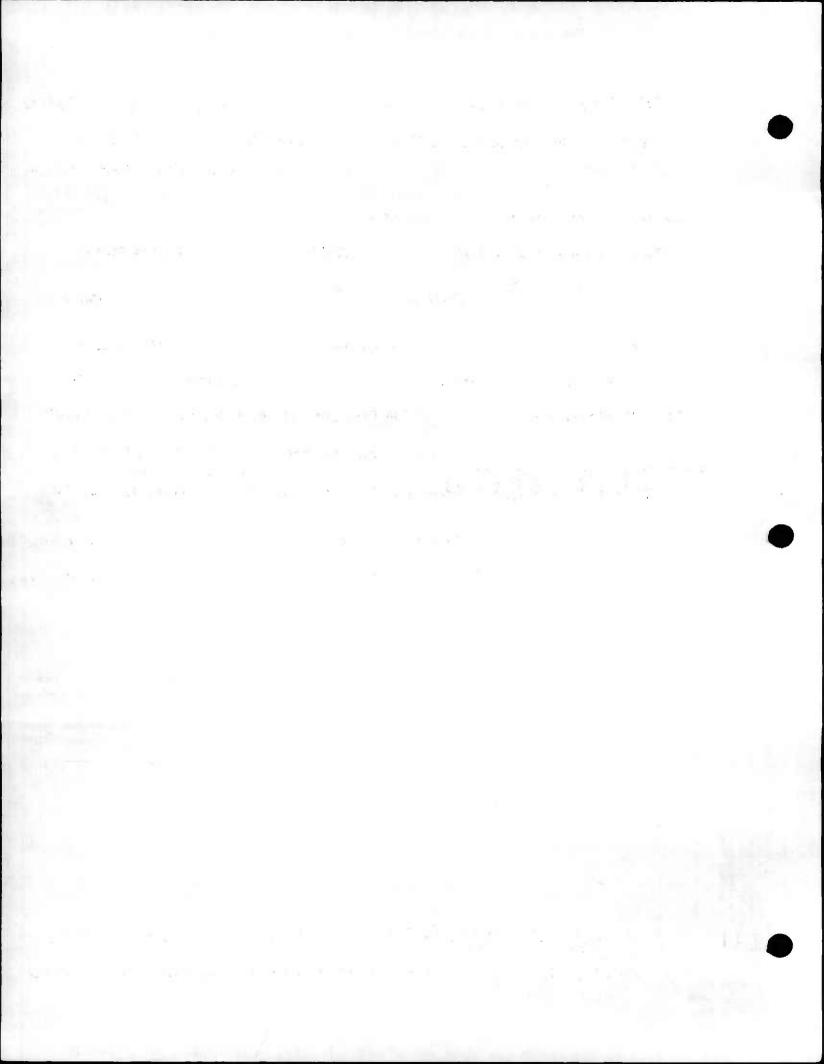
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death Day Month WHITE **Physician** KOBERT CHARLES JUL 1998 06 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
If Under 24 Hrs. 8 Date MONTGOMERY 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) **Funeral** Months Days 189 M 2□ F Vrs Director 220-03-0700 Dec. 22,1920 Washington, DC Usual Residence of Decedent the Marylend 10a. Stata 10c. City, Town or Location 10d. Instda City Limits 10b. County 7 is merked other than "naturel", or items 23a or 28a-f show treumstic event, tre Madical Examinar must be not lined at 1 ☐ Yas 2 No Director Maryland Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20004 Sweetgum Circle, # 14 20874 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Btack, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours effer d Department of Health and Mental Hygiene. Important: if item 27 is merked other than "naturel", or item any injury or other treumetic event, tre Meycal Exercited 1 M Yas 2 No If Yas, Giva Yaer or Datas: 1942/1949 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) 8 Oil Company Mechanic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 Robert White White Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Doris V. White/Wife 20004 Sweetgum Circle, # T4, Germantown, MD. 20874 20b. Place of Disposition (Nama of cematery, crametory or other piece) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriat 2 K Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 7/7/1998 Alexandria, Virginia ura of Funaral Service Ltcansee 22. Name end Address of Facility DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximata Interval Betwaen Onset end Daeth Physician PNEUMONIA Immediata Causa (Final disease or condition resulting In death) /Medical Week Examiner Due to (or as a consequence of): Physician/Medical Examiner 4 MONTHS CANCER ettending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury Dua to (or as a consequence of) Box 68760, that initiated avants rasulting in daath) Last Dua to (or as a consequence of): signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ has been sig 24b. Were autopsy findings eveilable prior to completion of causa of death? Completed 24a. Was an autopsy parformed' 2 No 1 □ Yas 2 ₽ No 1 ☐ Yas certificate Division of Vital or Attending Physician: director Be 25. Was casa rafarred to medicat axaminer? 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatlant 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 2 No Certification: To 1 Yes this After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturat 5 Panding invastigation death. 1 Yas 2 No 2 Accidant Director: / 6 Could not be datarmined 3 Suicida Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straal, factory, office building, atc. (Specify) 4 - Homicide within 24 hours aft To the Funerei Dis completely filled in Hospital edicai 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated. Till Certifying Physician: 10 tha best of my knowledga, death occurred at the lime, date and place, and due to the causa(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the lime, date and place, and due to the causa(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifiar 29c. Licansa number 2 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) 9707 MEDICAL CTR DR ROCKVILLE NA 20850 JOSEPH M. HAGGERMY MD State Registrar



the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by

DIVISION OF VITAL RECORDS, P.O. BOX 68760 OR ATTENDING PHYSICIAN:

29b. SMATURE AND TITLE OF CERTIFIEF

BE

executed within

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY **EMMA** WINSHIP Α JÜLŸ 15. 1998 2:30 PM 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 06/14/1907 219-36-0759 1 M 2 X F 90 MARYLAND 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MANOKIN MANOR NURSING HOME PRINCESS ANNE SOMERSET RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND SOMERSET PRINCESS ANNE 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit in prior to burial, cremation, or removal. 11974 EDGEHILL TERRACE 21853 USA 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 - Merried BY 1 TES 2 NO Specify: Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) ntary/Secondary (0-12) 12 REGISTERED NURSE MEDICAL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumerne) notified at ALVIN A. WINSHIP ROSE SIMMONS BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 EDWARD WINSHIP/NEPHEW 13439 HARRISON ROAD, PRINCESS ANNE, MD. 21853 Pe 20e. METHOD OF DISPOSITION
1 Burlet 2 Cremetion 3 R 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must LISBURY CREMATORY 4 Donation 5 Other (Specify) SALISBURY, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME 21853 11673 SOMERSET AVE., PRINCESS ANNE. MD medical PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death event, the arterioselerolie disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events attending resulting in death) LAST 6 signed by the atter Health and Mental I PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Obernie Obstructive Pulmoner 1 - YES 2 1 NO DF DEATH? neumonia 1 TES 2 NO ō DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\sqrta\) UNCERTAIN \(\sqrta\) PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSPITAL OTHER:
4 % Nursing Home 5 - Residence 6 - Other (Specify) 1 TES 2 NO 1 Inputient 2 ER/Outputient 3 DOA 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? this c marked, 26d, DESCRIBE HOW INJURY OCCURED 1 📉 Natural 5 Pending M 1 YES 2 NO BY After death 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28 18 26t, LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end dus to the cause(e) end menner ee stated. TO THE HOSPITAL D
TO THE FUNERAL D
be filed within 72 ho 2 MEDICAL EXAMINER: On the beels of end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end menner ee stated.

GREGORIOM. BELLOSO, M.D. 5302 CHINABERRY DRINE, SALISBURY, MD 2180

29c. LICENSE NUMBER

29505

29d. DATE SIGNED (Month, Day, Yber)

Alban File S II a

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month N. WASHINGTON 1998 09 JULY 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ROCKVILLE 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Months Deys 1□M 200 F Hours 72 1926 Yrs. 10c. City, Town or Location 10b. County Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 20850 U.S.A.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show any Injury or other traumatic event, the Mexical Examinat must be notified anones. Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner The law requires that the death certificate be executed peen : this funoral After

the Maryland

physician and s tha burial-transit for use as 1 signed by the a ils certificate has t I director, paga 2 s

Hospital or Attending Physician: 24 hours after death.

Division of Vital Records, P.O. Box 68760,

hin 24 hours after the Funeral Direct mpletaly filled in b To the To the

Director: /

State Registrar

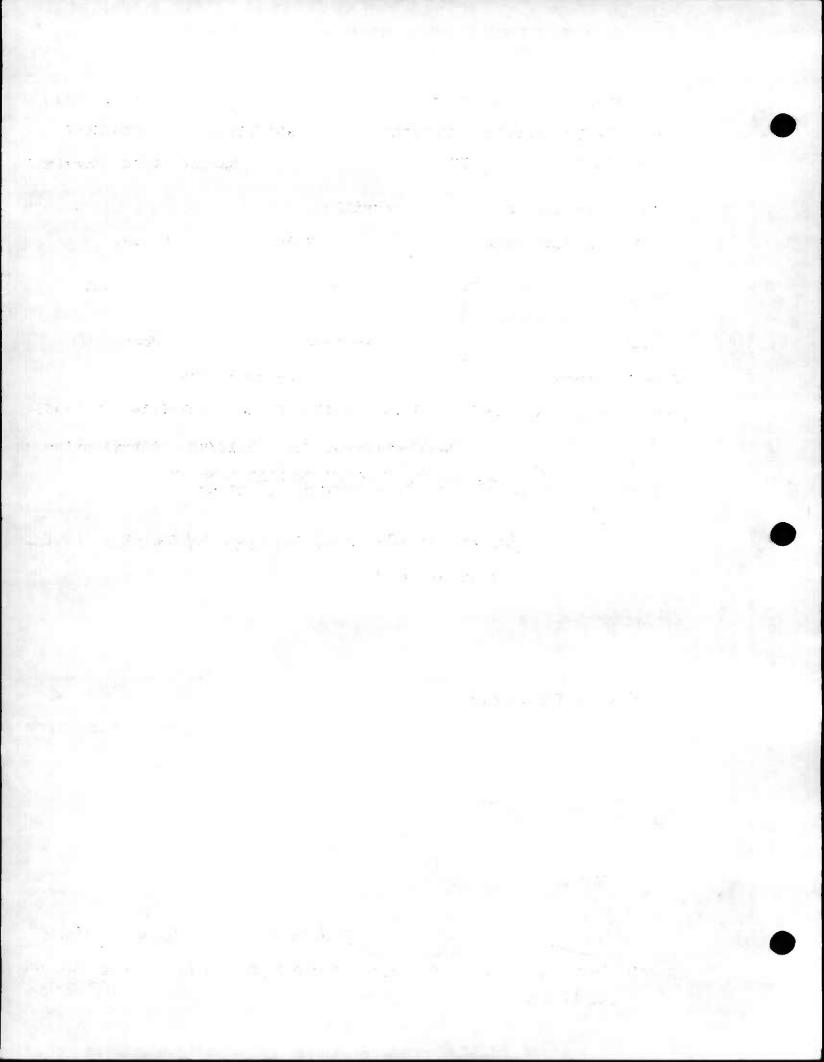
Physician 0821 HAVANNA /Medical 4e Fecility Neme (If not Institution, give street end number) Examiner SHADY GROVE ADVENTIST HOSPITAL 9. Birthplece (State or Foreign Country) 6 Maryland 5. Sociel Security Number **Funeral** 218-24-0522 Director Usual Residence of Decedent 10e. Stete 10d. inside City Limits Yes 2 No MD Director 10e. Street end Number 515 Longwood Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bieck, White, etc. 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: 1 □ Never Merried 2 □ Married Specify:Black 1 Yes 2 No Specify: þ XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) 9th Coilege (1-4or 5+) Home Maker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Sarah P. Lee Joseph Johnson 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17211 Epsilon Place, Rockville, MD 20855 Peggy Moore (Daughter) 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriei 2 ☐ Cremetion 3 ☐ Removal from State Parklawn Mem. Cem. 7.14/984 ☐ Donetion 5 ☐ Other (Specify) Rockville. MD 21. Significant Funeral Service License 22. Name and Address of Fecility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 Approximete Intervet Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or head failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY WL DISTRESS diseese or condition resulting in death) Due to (or es e consequence of): Physician/Medical Examiner NEUMONIA Sequentietly list conditions, if eny, teading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PERTENSION þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes ZENo 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 25 No 1 Suppatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how tnjury occurred Certification: 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end manner es steted. 29e. Certifier Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

purson who completed cause of death (Item 23a) (Type, Print) 8609

AVENUE, #404 B SILVER SPRING

D 28656

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day 1998 ee July 10, 3:16 AM SEDONIA WASHINGTON 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Prince Georges Laurel Regional Hospital LAUREL Hours Min. July 13, 1920 9. Birthplece (State or Foreign Country) Maryland If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) Deys 1 M 200 F 77 Yrs 217-20-2759 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits NE Yes 2□ No Prince Geo. Bowie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. Box 182 20719 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 20 Merried Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Charles E. Carroll Mary E. Robinson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph G. Washington (Husband) P.O. Box 182, Bowie, MD 20719 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremation 3 ☐ Removel from Stete Md. Nat'l Mem. Park 7/15/98 4 Dopati 5 Other (Specify) Laurel, MD ral Service Licensee Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. MOROCKVILLE, MD 20850 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

requires that the daath certificata be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

Funeral

Director

show

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

7 is marked other treumatic event, I

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other treumatic event and Injury or other treumatic event and

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0020

Examiner sician and burial-transit attending physician Physician/Medical the use as t o ed by the a signed b þ has l

page 2 should Completed director, Be 10 filled in by the funaral Certification:

certificate

After this

Hospital or Attending Physician:

To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al

10

Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

NAEMIA FREBRO. VASCULAR ACCIDEN 25. Wes case reterred to medicel exeminer? Hospital: 1 Impatient 2 EFVOutpetient 3 DOA 1 Yes 2 No

24e. Wes en eutopsy performed? 2 No 1 Yes

28d. Describe how Injury occurred

24b. Were eutopsy tindings eveileble prior to completion of cause of deeth?

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

No 1 TYAS

21094

28c. Injury at Work? Date of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

27. Marmer of Death Naturel

2 Accident

4 - Homicide

3 Suicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

Medical Example: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certific

6 Could not be

29c. License number

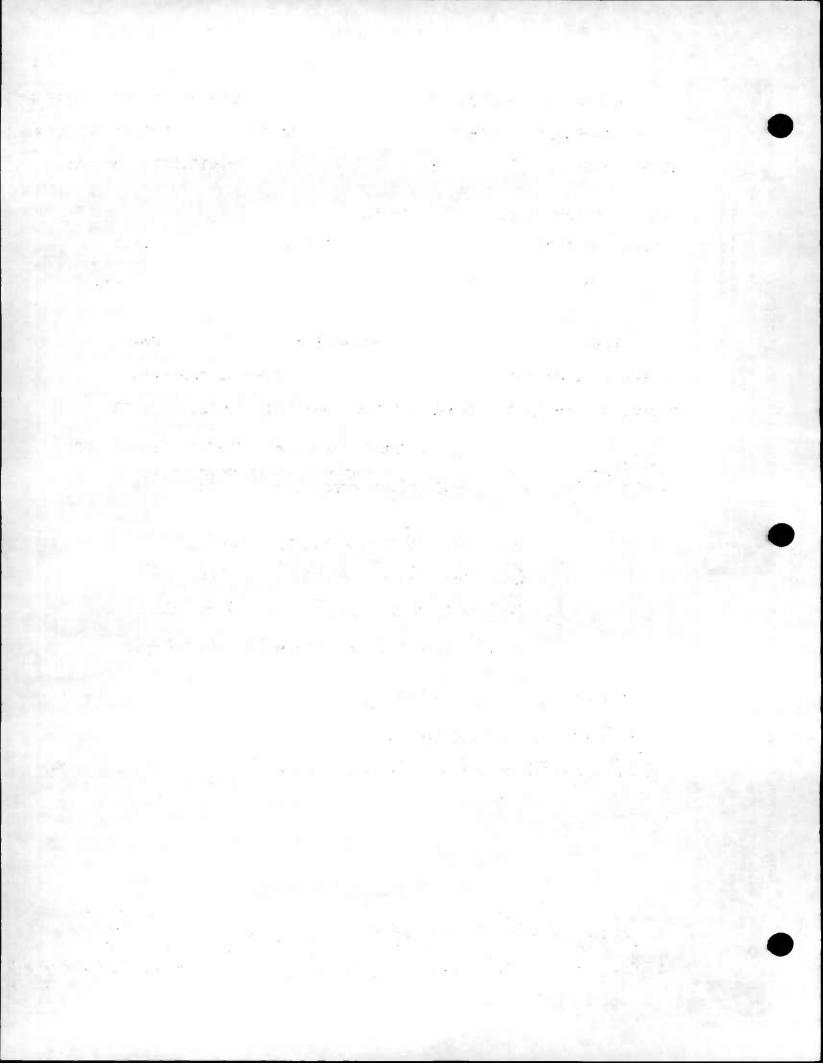
29d. Date signed Month, Quy, Year)

31. Dete filed (Month, Day Year)

32 Registrer's Signeture Ma Davidson

State Registrar

edical



MATTHEW CALEB WAYMAN Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Depart

121	Date of Dooth			2	Time	of I	$\overline{\lambda}$
rtificate of Death	Reg. No.	20		J	U	J	
artment of Health and Men	ital Hygiene	0,0	2 0	2	0	0	0

JULY 15,1998

Month

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Lest)

Funeral

Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

	Matthew	C. Wa	aymon			JULY	Dey 14, 19	998	12:50P.M
4a Fecility Name (If not institution, giv EAST WEST HIGHWA	·	AVE				vn, or Location of Dec IESDA		of Deeth	Y
5. Social Security Number 6. S 214-17-6558		(In yrs. last bir		Jndar 1 Yeer nths Deys	If Under 2 Hours	Min. April 1	Birth Pear) 9, 1982	9. Birthp Cour	olece (State or Foreigntry) India
Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow						1	10d. Inside City Llmit:
Maryland Montgome	ery	Silve	r Spri				1 40 000	100	
10e. Street end Number	10		10	7. Zip Code 20910			10g. Citizen of		
622 Ritchie Avenu	12. Was Decedent E	vor in II S	12 Weel		disponia Orla	gin? (Specify Yes or I	United		⊇S can Indien,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes	specify Cub es 2 🕅 No	Specify:	, Puerto Rican, etc.)		ck, White,	etc.
15. Decedent's E (Specify only highast green statementery/Secondary (0-12)	ducation ede com <i>platad)</i> College (1-4or 5-	+)	(Giva kind	Usuel Occup of work done OT use retired	during most	of working	16b. Kind of B		
17. Fathar's Nema (First, Middle, Last,)	1			18. Motha	r's Neme (First, Midd			
E. Todd Waymor	n				E.	Lynne Bai	rnthouse		
19e. Informent's Neme/Relationship (Type, Print) (pare	ents) 19t	b. Meiling Ad	Idress (Street	end Numbe	r or Rural Route Nun	nber, City or Town	Stete, Zip	Code)
E. Todd & E. Lynn	e Waymon	S	ame as	10					
20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	Removel from State	20b. Placa o cemete	of Disposition ery, cremetor	(Neme of y or other ple	ce)	Date	20c. Location	City or To	own, Stete
4 Donetion 5 Other (Specif		Chesap	peake	Cremat	ory	7-16-98	Beltsvi	lle,	Maryland
21. Signature of Funeral Servica Licer	7 0 D~	~ 1				vices, P. Silver S		D 209	910
Immediate Cause (Final disease or condition resulting in death)	b	Multiple Due to (or as e							
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted avents	c	Due to (or es e							
resulting in deeth) Lest	d						7		
Part II. Other algnificant conditions of	ontributing to death but	t not resulting i	in the underl	ying cause gi	ven in Part I.		ld tobacco uee co		o the cause of death bably 4 thnknow
						24e. W	es en eutopsy priormed?	ev	ere eutopsy findings ellable prior to impletion of cause deeth?
						1)	Yes 2□No	10	Kyes 2□ No
25. Was case referred to medical examiner?				12	_	of Death (Check on	ly one)		
1 Yas 2 No	Hospitel: 1 ☐ Inpatien			L DOW		rsing Home 5 ☐ Re			W) SCENE
27. Menner of Deeth 1 □ Neturel 5 □ Panding 2 □ Accidant investigation	1/17/78	Year) 28b.	Time of Injury	28c. Injui Wo	yet rk? Yes 2./25⊀		be how injury occu by vehicle		inda
3 Suicide 6 Could not b 4 Homlcide determined	28e. Placa of Injurbuilding, etc.	ry - At home, fa (Specify)	arm, sheet, f	ectory, office	4	Min. au *	(Street end Num. Town, Stete)		al Route Number,
29a. Certifier (Check only one)	yelclan: To the best of ninar: On the basis of end menner stat	exeminetion er	e, deeth occ nd/or Investig	urred et the ti getion, in my d	me, date end opinion, deet	d plece, end due to th	he ceuse(s) end m	anner es s and due t	iteted. o the ceuse(s)
29b. Signatura and title of certifier			-	29c. Licans	sa number		29d. Date signe	ed (Month,	Dey, Year)

O.C.M.E.

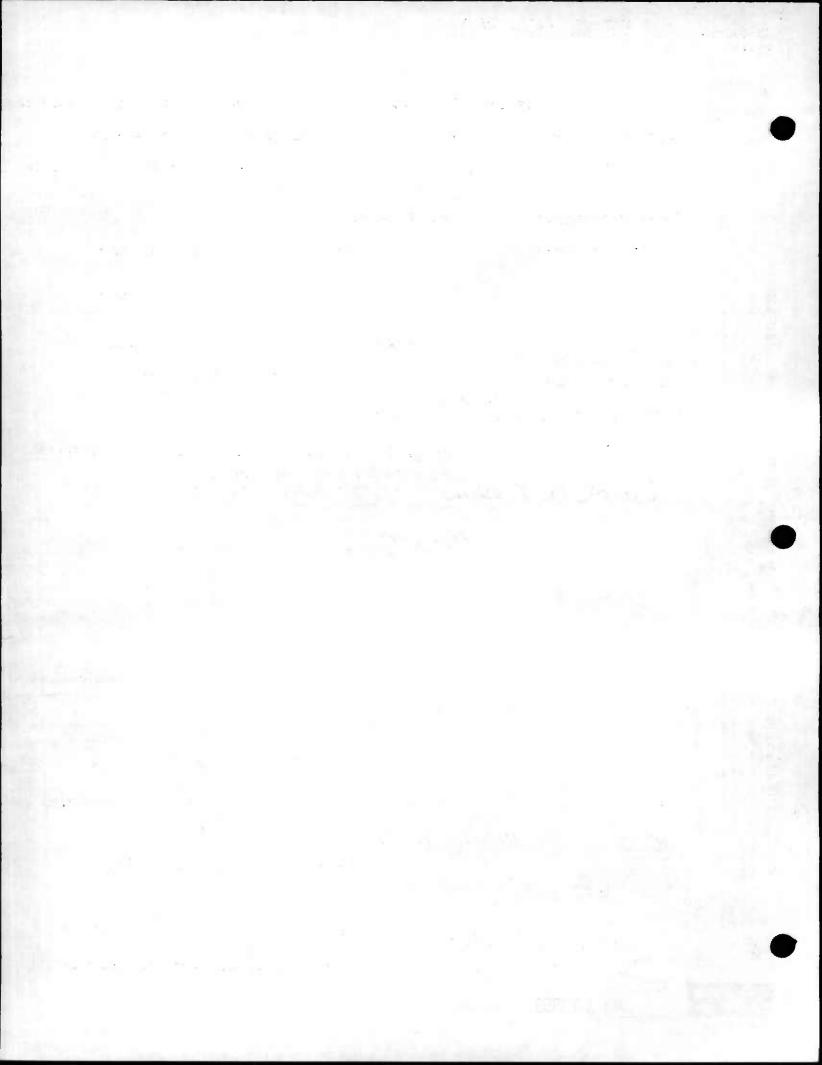
State Registrar

31. Dete filed (Month, Dey, Year)

JUL 1 7 1998

30. Name and address of person with completed cause of death (Item 23e) (Type, Print)

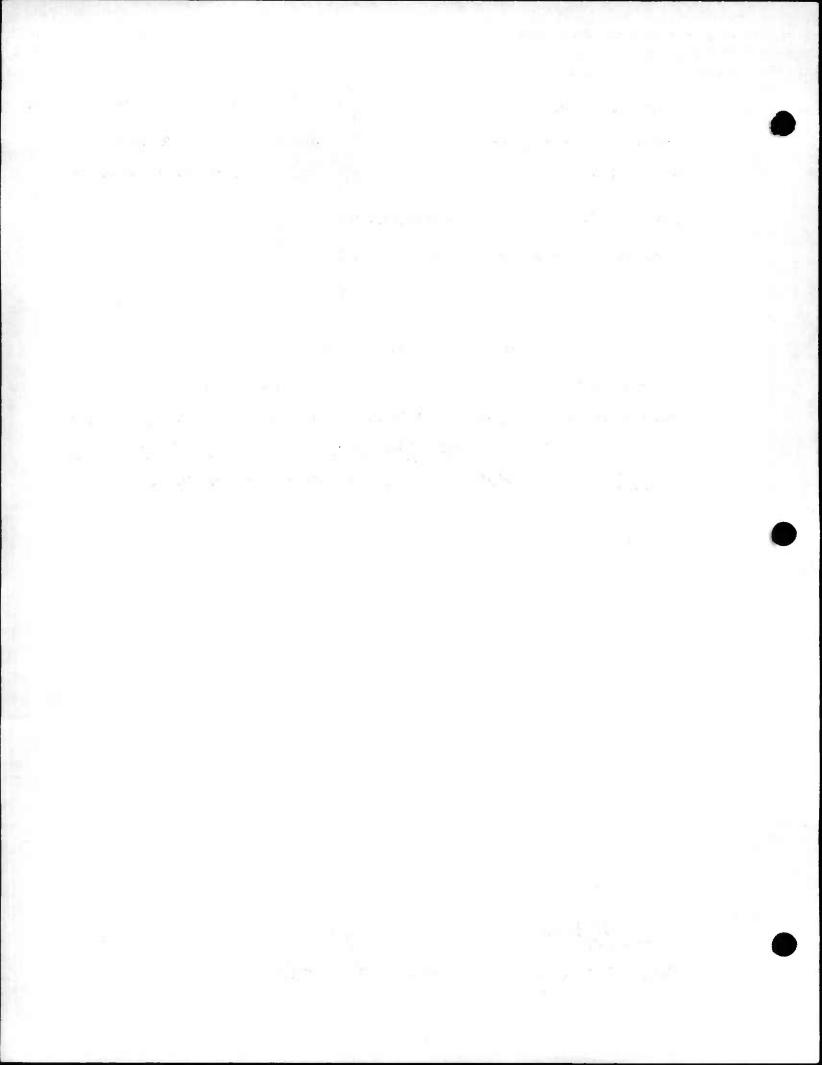
111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura Little Davidson-Randale



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of W	arylar		Certifica		Death	Mental H	Reg. No.	3 2:	3034
	Physici /Medi		1. Decedant's Name John A	(First, Middle, La 11en Wej							2. Dete of D Month	eeth Dey	Yeer 198	3. Time of Death
8	Examir		4e. Fecility Neme (if r)				4b. City, Town, or				
			Brooke Gr	ove Nurs	sing Home					01ney		Montg	omery	
	Funeral		5. Sociel Security Nur		Sex 7. Ag	ga (In yrs.		Months	er 1 Year Deys			irth Day, Year)	9. Birthple	ce (Stete or Foreign
	Director		578-03-20	58	LAIM ZUF	8:	2 Y	rs.			March	15,1916		
	and w		Usuet Rasidance of D	l 0b. County		10c. Cit	v. Town	or Location					100	I. Inside City Limits
	Aaryl sho	5		50									100	1⊠ Yes 2 □ No
	the 1288	Director	N/A 10e. Sfreet end Numb	N/A		was	snin	gton, 1	ip Code			10g. Citizan of	What Counts	0
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	Jeath Trs 2:	Funeral	2801 Queb	ec Stree	12. Wes Decedent	#3371 Ever in U			20008 edent of F		Specify Yes or N	USA lo- 14. Rac	e - American	Indien.
0	the results	Ē	1 ☑ Never Married	2 Married	Armed Forces? 1 ☐ Yes 2 ☒					lispenic Origin? (S en, Mexican, Puer	to Rican, etc.)	Bled	ck, White, etc	
0 5	al', o	by	3 ☐ Widowed 4	Divorced	If Yes, Give Yeer or Detes:			1 🗆 Yes	2⊠ No	Specify:		Specify	" Whit	e
2-0	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or flems 23a or 28a-f show ent, the Medical Examinet must be notified at	Completed	(Specify	5. Decedent'e Ed	ducation		16e. [Decedent's Us	uel Occup	pation	vekina	16b. Kind of B		
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2	ygier ygier her th	Co			5+		App	eals E	xamir	1		Law		
and	d out	Be	17. Fether's Name (Fi	irst, Middle, Last)						18. Mother's Ne	me (First, Middl	e, Meiden Sumen	ne)	
2	Mer Marke	To	George	Weil						Agnes	Roth			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Haelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🗆 Burial 2 🗆	Cremation 3 3	Removel from Stete	Wes	emetery T Sw	amp Me	other ple	ite	Date	Quaker		1, Stete
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	tificate be axecuted ig physician and as the burial-transit	Examiner	Sequentially list cond	itions	b	Due to (o	res e co	onsequence of):				1	
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OS	uiras sign id be	d by									24a We	s en eutopsy	24b. Were	eutopsy findings
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Division of Vital	i or Attending Phattar death. Director: After this in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28a. Placa of Inj	ury - At ho	me, farr	n, streat, facto	ry, offica		28f. Location	(Street end Numb	er or Rurel F	Routa Number,
ā	rs after or all Direction	Cer	42 (10)		building, et	c. (Spacin)	')				Only or 10	JWII, State)		
	To the Hospital or Attending Physician: white 24 hours stafer death as the furnity or fifty To the Furneral Director: After this certification and the function of the functio	edicai	CHECK DINY 2	Certifying Phy Medical Exam	ysician: To the best	of my know	wladge,	deeth occurred or Investigatio	d et the tin	ne, date end plece	e, and dua fo the	a causa(s) end ma	annar as state	ad.
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			75U7 6	or person who o	completed cause of d	leeth (Item	23e) (T	ype, Print)	7	MD	217	21		
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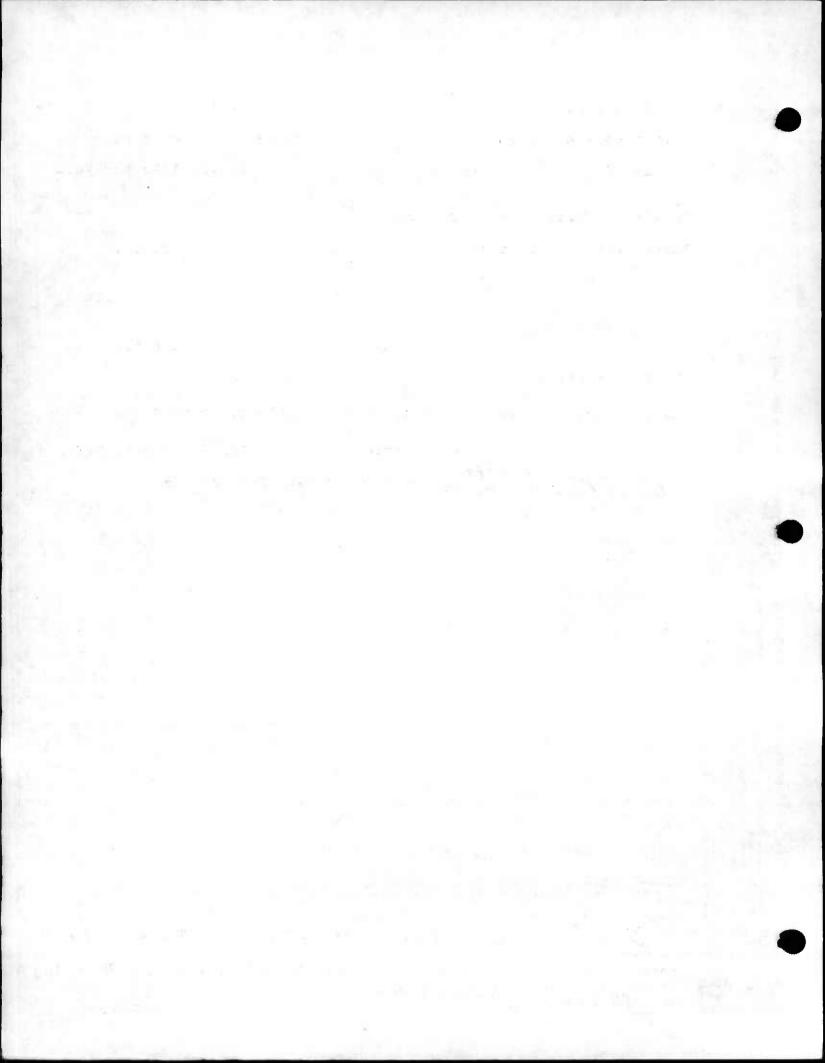
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	_				Cei	rtificate	e of l	Death		R	eg. No.		
ysici	ian	Decedent's Name (First, Middle,	Last)							Date of Deat Month	th Day	Year	3. Time of Death
Medic		Paul Weinst								uly	15, 1	998	7:00am
amir	ner	4a. Fecility Name (If not institution,							vn, or Location	on of Death	4c. County	of Death	
		Manor Care of 5. Social Security Number		(In yrs. last	hirthday)	If Under 1		Potor If Under 2	4 Hrs. 9 r	Date of Birth	Mont	O Bish	ologo (Cinto ou Comis
ral or		114-24-6292 Usual Residence of Decedent	1□XM 2□F 6.		Yrs.		Days	Hours	Min. J	Month, Day, an. 20	Year) 0,1933	New	plece (State or Foreigntry) York
	Director	10a. State 10b. County Maryland Mon	tgomery	Poto								1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Dire	10e. Street and Number 11105 Hurdle	Hill Drive			10f. Zip (Code 085	/		1	0g. Citizen of 1		ntry?
	Funeral	11. Marital Status	12. Was Decedent Ev	er in U,S.	13. \	Was Decede	ent of Hi	spanic Orig	in? (Specify	Yes or No-			can Indian,
	by	1 ☐ Never Married 2 【X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			If Yes, specif 1 ☐ Yes 2	ify Cuba	n, Mexican, Specify:	Puerto Rica	in, etc.)		ck, White,	etc.
	ted	15. Decedent's	Education	16	6a. Deced	dent's Usual	Occupa	ation	of wordsing		16b. Kind of B		
1	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	F	life. L	kind of work DO NOT use essol	e retired	iuring most)	of working		Educa	tion	
	Bec	17. Father's Name (First, Middle, La	est)					18. Mother	's Name (Fir	rst, Middle, A	Maiden Surnan	ne)	
	TOE	George Weins	tein					Anı	n Fla	m			
		19a. Informant's Name/Reletionship	p (Type, Print)	15	9b. Mailin	ng Address ((Street a	and Number	r or Rural Ro	ute Number	, City or Town,	State, Zip	Code)
		Alice Weinste:	in/Wife	1	1110	5 Hui	rd1	e Hil	ll Dr	. Pot	omac,	MD	20854
20a. Method of Disposition 1 Burlal 2 Cremetion		20a. Method of Disposition 1 Durial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spe		20b. Placa ceme Beth	tery, cren	esition (Name matory or oth vid	e of her place	e)		9/98	20c. Location -		
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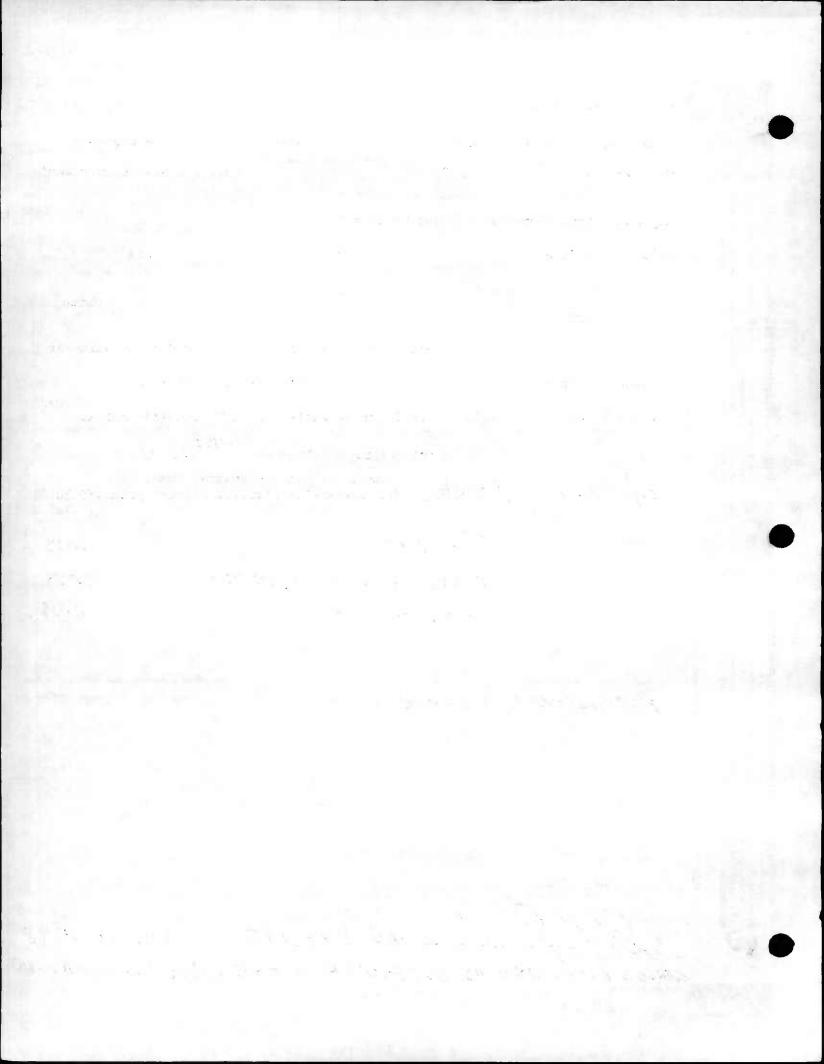
31. Date filed (Month, Day, Year) 1998



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					Certifica	te of	Death		Reg. No.		
	1. Decedent's Name (Firs	st, Middle, La	st)				100	2. Date of D	eath	Year	3. Time of Death
Physician	VICLOR SILV	vio Yo	cco					July	/ 13	1998	12:40cm
/Medical Examiner	de Casilla, Nama (Mast le	nstitution, giv	re street and numb	er)			4b. City, Town	, or Location of Dea			
Funeral	Washington 5. Social Security Number	r 8. 5		Age (In yrs. last	birthday) If Und	er 1 Year Days		Hrs. 8. Date of B Min. (Month, L	irth Da <i>y, Year)</i>	Coui	place (State or Foreign ntry)
Director	086-16-3575 Usual Residence of Dece			83	110.			Oct.	19,1914	Penr	nsylvania
and		County		10c. City, To	own or Location					T.	10d. Inside City Limits
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentel Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, me Medical Encounter must be notified at To Be Completed by Funeral Director	Maryland Pr	ince G	eorge's	West	Hyattsv	ille			10g. Citizen of	What Cou	1 ☐ Yes 2 ☑ No
with with	Constitution of				101. 2						
s 23	2415 Hannor	n Stre	et 12. Was Decede	ent Ever in II S	13 Was Dec	207		2 (Specify Yes or N	US. 14. Bas		cen Indian,
urs after death v sit, or items 23e	1 Never Married 2		Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X No	If Yes, sp	12		? (Specify Yes or Nouerto Rican, etc.)	Bla Specif	ck, White, y:	etc.
hour hour			The state of the s		6a. Decedent's Us	ual Occur	nation		16b. Kind of B		White
led within 72 ho ygjene. ner than "natura nt, me Medical	(Specify on)	Decedent's Ed by highest gra	ide completed)		(Give kind of w	ork done	during most of	f working	TOD. KING OF B	usiilessiii	idustry
within than	Elementary/Secondary	(0-12)	College (1-4		aritime S			lyct	Federal	Corre	rnmon t
filed within the other than ent, me went.	17. Fether's Name (First,	Middle, Last		Mic	illuline 3	ubsi		Name (First, Midd			erment
d be fill H sed out		Yocc					Edno	Rebecca	Whitford		
should I	19a. Informant's Name/R			1	19b. Mailing Addre	ss (Street	t and Number of	or Rural Route Num	ber. City or Town	. State. Zii	o Code) 20783
d 2 should be filed within 72 hours af th and Mentel Hygiens 17 is marked other than "natural", or traumatic event, the Medical Example To Be Completed by E	Ruth B. You		Wi		2415 Hann			West Hya			
1 and Health Hem 27 other tr	20a. Method of Disposition		MI	20b. Place	of Disposition (N	ame of		Date	20c. Location		
Pages nent of I	1 ⊠ Burial 2 □ Cred			ate	etery, crematory or			7/17/98			
	4 Donation 5 C		-	Georg	e Washin		Cemete ess of Facility	ry	Adelphi	, Mar	yland
pemit. Departn Importa any Inju	21. Signature du runeral.	Service Licei	0 +	1.15	Franci	s J.	Collin	ns Funera	1 Home,	Inc.	
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Examiner	resulting in death)		a	Due to (or as	a consequence of): /	0.00	. 1			
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need nould								24a. Wa	as an autopsy rformed?	a	vere autopsy findings valtable prior to ompletion of cause
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or A after Directify	4 Homicide	Jeter Hillied	building	, etc. (Specify)		,			own, State)		
To the Hospital or Attending Physician: The law require within 24 hours after deeth. Ye the Funeral Director: After this certificate has been significated in by the funeral director, page 2 should Medical Certification: To Be Completed				s of examination				place, and due to the occurred at the time			
within To the compl	29b. Signature and title	f certifier		/	AA 2	9c. Licen	se number	70	29d. Date sign	ed (Month	, Day, Year)
NO	She	14	mb		11.0-	リナ	827	0	2018	17	1778
	30. Name and address/of	person who	ARRUBIA	of death (Item 23 95 8/2	a) (Type, Print)	SIP	AUE #	1405 SI	WER SA	UNG	MD 20910
State Registrar	31. Date filed (Month, Da	y. Year) 1	32. F8g	ietrar Signature	- Pondalla	;					

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth Month ZIRKLE 07 12 98 1433 J

1 Yes 2 No

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Funeral Director

deeth with the Maryland ral', or items 23a or 28a-f show Examiner must be notified at Directo Funeral permit. Pages 1 and 2 should be filled within 72 hours effer a Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, trained and any other traumatic event, trained and any other traumatic event. þ Completed Be 2

Baltimore, Maryland 21215-0020

Physiclan /Medical Examiner

Examiner

Physician/Medical

à

Completed

Be

2

Certification:

edical

29b. Signature and title of cartifier

31. Date filed (Month.

Day, Year)

D.M.E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ettending physician and for use as the buriel-trensit The lew requires that the death certificete be executed been signed by the should be deteched page 2 s s certificate hes director, page 2

Box 68760. P.O. Records, Division of Vital tal or Attending Physician: Tre effer deeth.

In Director: After this certificated in by the funeral director, pa n 24 hours efter de ne Funeral Directo pletely filled in by th Hospital To the Hosp within 24 hou To the Fune completely fi

LAURA 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthdev) 8. Date of Birth (Month, Dey, Birthplece (State or Foreign Country) 1□ M 200F North Carolina 12-06-19 238-03-1201 Usual Residence of Dacedeni 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Berlin Maryland Worcester 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21811 United States 54 Ocean Parkway Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritet Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Homemaker Own Home 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Sally Maxwell Walter Lee Jenkins 19a, Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 217, Ocean City, Maryland 21843 Anne L. Zirkle/Daughter in Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State July 17, 1998 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Fecility Robert A. Pumphrey Funeral Home 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

23a. Pert1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Funeral Home/Bethesda-Chevy Immediata Cause (Final disease or condition resulting in death) HEPATIC FAILURE Due to (or es e consequenca of): ALCOHOL ABUSE Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of) Part II. Other afgnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COMPRESSION FRACTURE C-4; DIABETES MELLITUS; SEPSIS 24b. Were autopsy findings evallable prior to completion of cause of daeth? 24e. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. fnjury at Work? 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 06-17-98 2 Accident FELL—LEVEL SURFACE
28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide HOME-PO BOX 217 OCEAN CITY MARYLAND 29a. Certifier 1🖵 Cartifying Physician: To the best of my knowladge, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 20 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. (Check only one)

29c. License number

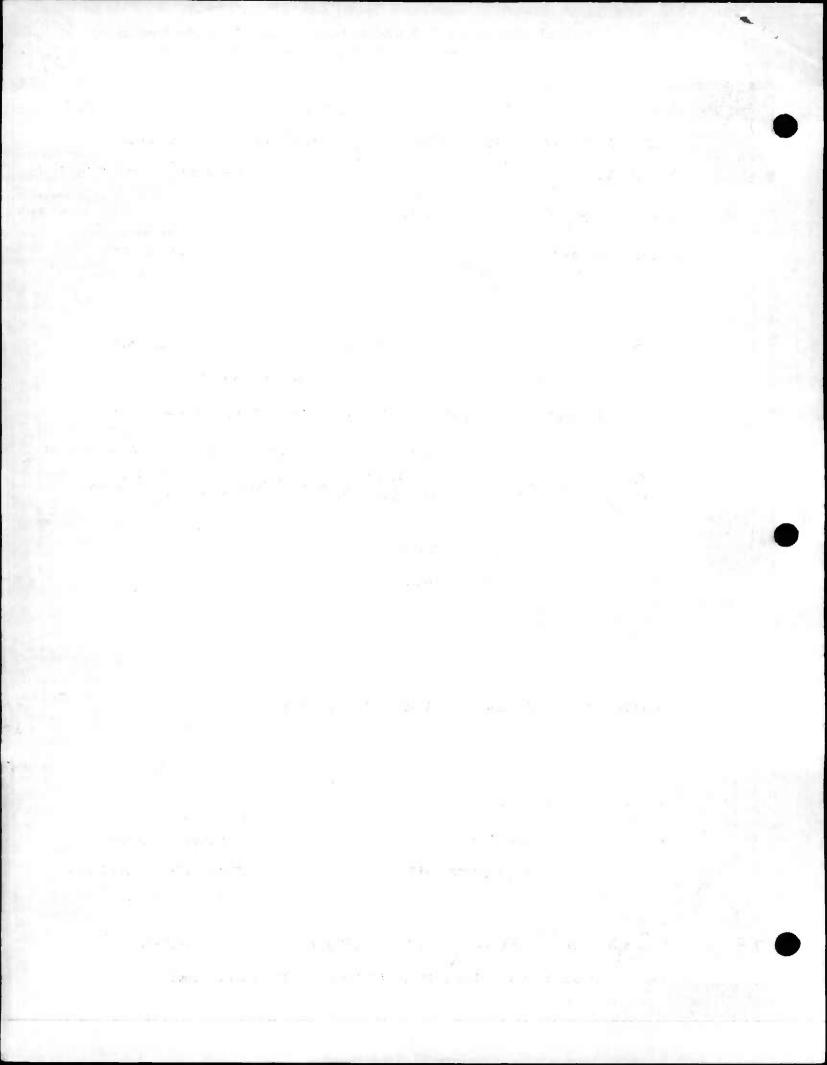
D03599

BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

29d. Date signed (Month, Dey, Yeer)

07-13-98

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month JEAN ALVEY 1998 0415 23 0 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death HOSPITAL BALTIMORE N/A If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 12/29/1899 If Under 1 Year Birthplece (State or Foreign Country)
 MD . 5. Social Security Number 7. Age (In yrs. last birthday) Deys Months 1□ M 2 F Yrs. 217-54-2008 98 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1⊠ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2211 West Rogers Ave. 21209 USA 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Raca - American Indien 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H.D. Bennett Jane Jordan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Courtney D. Alvey (son) 8810 Walther Blvd. Apt. 2427 Baltimore, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 7/27/98 Druid Ridge Pikesville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) Carrolle Name and Address of Fecility Ruck Towson Funeral Home, Inc. 21. Separture of Funeral Service Licensee Dennis C. 1050 York Rd. Towson, MD. 23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock or heart feiture. List only one cause on each line. Approximate Intervet Between Onset end Death e. PULMONARY EDEMA RESP. FAILURE tmmediete Ceuse (Finel disease or condition resulting in death) CONGESTIVE HEART FAILURE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury Due to (or es e consequenca of): that Initiated events resulting in death) Lest Dua to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the causa of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? No 1 Yes 2 | No 1 Yas 26. Plece of Deeth (Check only one)

Physician /Medical **Examiner** Physician/Medical Examiner

Physician

/Medical

Examiner

10a. State

MD.

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examinating must be not lest at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "natural", or itema 23a any highly or other treumatic event, the Medical Examiner mass once.

with the Maryland

Sician and attending phy . page

9

Completed

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Certification:

edical

29b. Signeture and title of cartifing

The law requires that the death certificate be executed this certificate has been signed by the ral director, page 2 should be datached Hospital or Attending Physician: 24 hours after death. After this funeral of Director: / To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the

Division of Vital Records, P.O. Box 68760

THROMBOCYTOPENIA 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 12 Naturel 5 Panding 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Phyeicfan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

Medical Exeminer: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier

State Registrar

29d. Date signed (Month, Day, Year) 29c. License number

SINGER MO AS2402321-CS-921 Oraia Inger, 2401 Belvedere Ave, Balto. mi

31. Date filed (Month), Day, Year) legistrar's Signature The Davidson—Randell

Maria de la companya

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#31 per DVR G761 7/28/98 EW 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JOLY 294 1998 ERVIN GEORGE 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Death BALTIMORE HOSPITAL 900 CATON AV BALTIMORE AGNES If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthday) 186-22-23/6 1 M 2□ F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tas 2 □ No BALTIMORE 10e. Street and Numbe 10g. Citizen of What Country? U-5.A 21229 257 12. Was Decedent Ever in U,S. Armed Forces? 1 12 Yes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Spacify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) ocksmiTH LOCK & KE 18. Mother's Nama (First, Middla, Maiden Sumeme, 17. Father's Neme (First, Middle, Last) 570N 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jeformant's Name/Reletionship (Type, Print ST. BALTO. MD. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State REENMOUNT 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Peneral Service Moansas 4015. CHESTEL ST 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting In death) METASTATIC LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 MUnknown 24b. Wera eutopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? 2 18 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural Injury 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Director

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permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mental Hygiene.
Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner n Pa

the funeral director, pege 2 should certificate has or Attending Physician: After this

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Certification:

edical

2 Accident

3 ☐ Suicide

29a, Certifian

ATYNA

4 Homicide

29b. Signature and title of certifier

Records, P.O. Box 68760,

Division of Vital

within 24 hours e completely To the

Hospital

death.

efter death Director:

In by

31. Dete filed (Month, Day, Yeer)

KORZAN

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

15. Certifying Physician: To tha best of my knowledga, death occurred at tha tima, dete and place, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

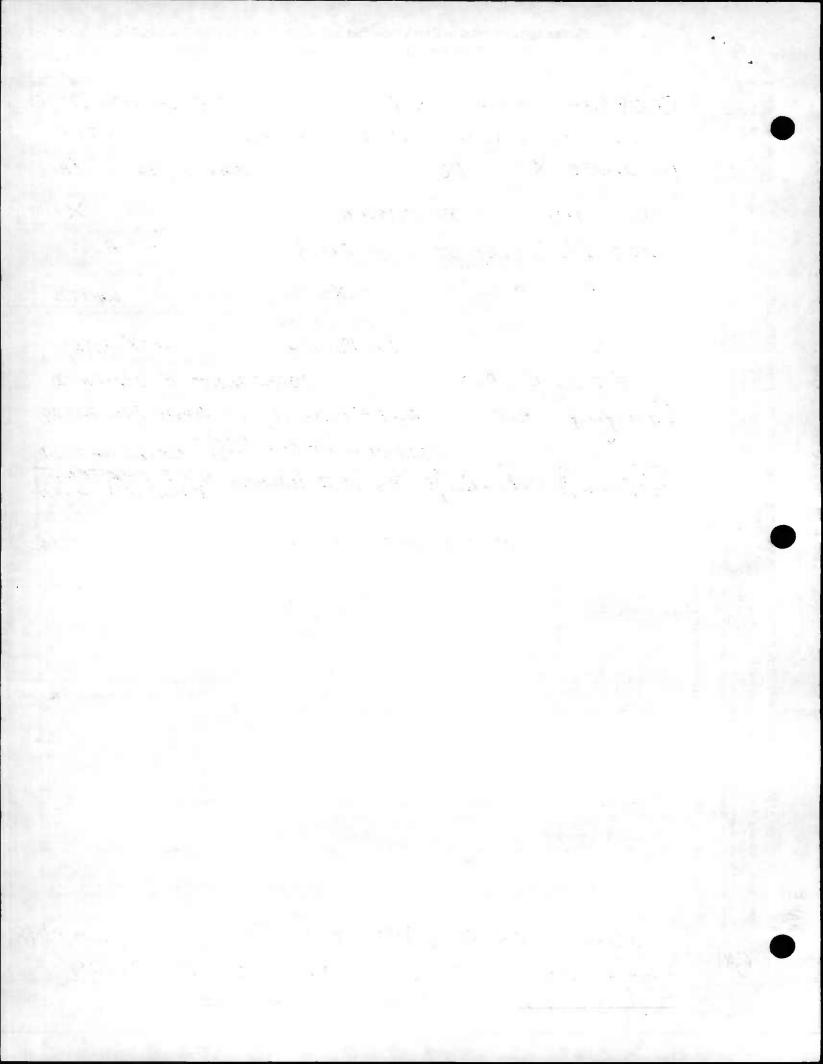
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32. Registrar's Signature

JUL 281998

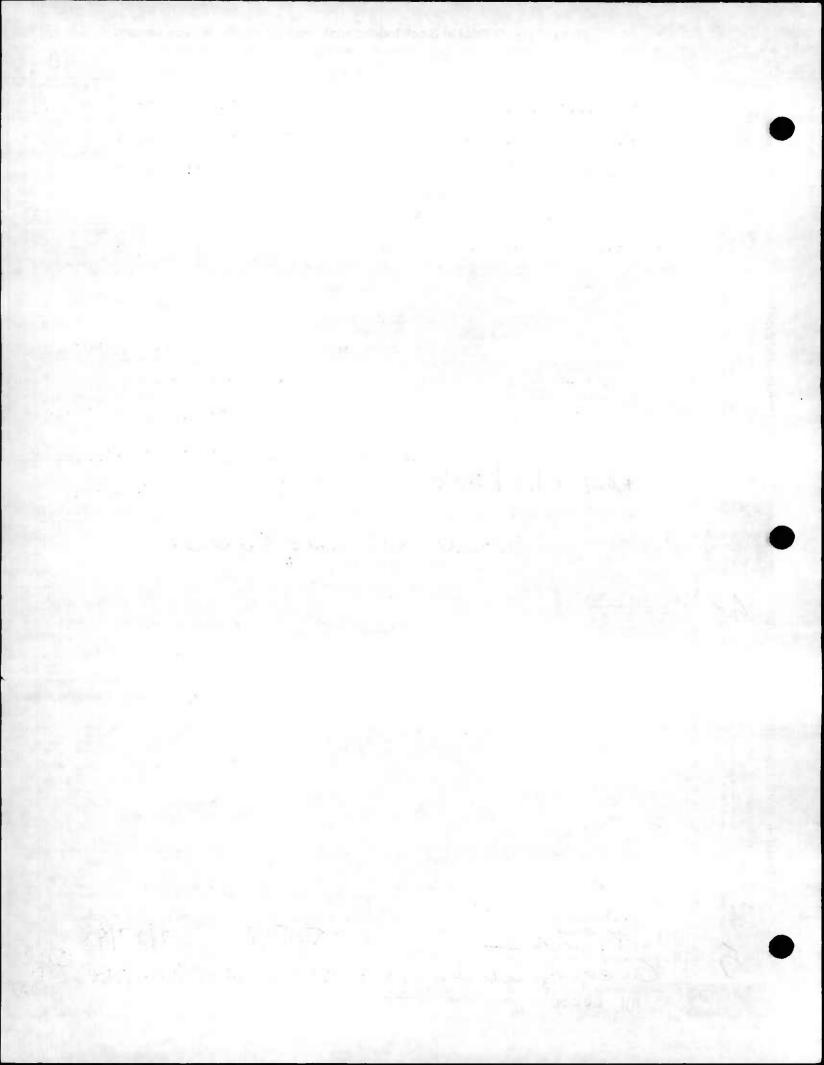
MD

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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or 28	10e. Street end	Number				Zip Code			10g. Citizen of V	What Country	y?
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or he	11. Maritel Stat 1 □ Never I 3 □ Widow	us Married 2 Married ed 4	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Detes	s? XNo		ecedent of I specify Cub s 2 No	Hispenic Origin? (Sean, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	Specify	a - Americar ck, White, et Whit	c.
72 hours of natural, or deal Exam		15. Decedent's Ed			16e. Decedent's I	Jsuel Occu	petion	41-	16b. Kind of Bu		
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12 sho h end is me traume		's Name/Relationship (ct Leroy	** 1	00 n			t and Number or Ro				
1 end Health em 27 ther tr	20a. Method of		DLOOKS				nger Roa	Dete DET	20c. Location -		
permit. Pages 1 end Department of Health mportant: If Item 27 any injury or other to ance.	1 🗆 Burial	2 Cremetion 3		10	Pleca of Disposition emetery, cremetory						
permit. Pag Department important: If any injury o		on 5 Other (Specif		N	letro Cr	emate	ory, Indess of Fecility	c 7/27	98 Ba	1time	ore, MD
permit. Departimportu	21. Signature	Funeral Service Licer	mc Ho	nalo			on Socie	etv of	Marvla	nd.	Inc.
	Da	wn F. Mc	Donal'd		299	Free	derick 1	Rd. Bal	to. MD	2123	28
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	Decedent's Name (First, Middle, La	et)	C	ertificat	e of	Death	2. Date of Deat	g. No.	3. Time of Death
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/Medical	wayne Mich					4b. City, Town, or I	July 25	, 1998 4c. County of	3:30 PM
Examiner	4a Facility Name (If not institution, give Gilchrist Center	e street and number)				Towson	LOCATION OF DOGIN	Balti	
	5. Social Security Number 6. 5	Sex 7 Age	(In yrs. last birtho	(av) If Under	1 Year	If Under 24 Hrs.	8. Date of Birth		
Funeral Director		XIM OF F	59 Yrs	Months		Hours Min.	8. Date of Birth (Month, Day, 12/14/1	Year) 938	Birthplace (State or Foreign Country) MD .
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Pet Pet	MD. Baltimon	ce	Freeland						
ifier death with the Marylan r Items 23s or 25s-f show ricer must be notified at Funeral Director	10e. Street and Number 19959 Gore Mill	Rd.		10f. Zig			1	0g. Citizen of W USA	nat Country?
ors efter day	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 2 Yes 2 □ No If Yes, Give Yeer or Dates: P		1 □ Vas		Ilspanlc Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, k, White, etc. White
g * 3	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)) (G		al Occup rk done se retire	pation during most of world)	rking		siness/Industry
			Mark	eting		19 Mother's Na	me (First, Middle, M		ications
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should be and Mentel marked o umaric eve									
0 0 0	19e. Informant's Name/Relationship (19b. N	telling Addres	s (Stree	r end Number or Ri	ural Route Number	, city or Town,	State, ZIP Code)
Heali Heali Heali thar	Mary E. Barry (v 20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □	Removal from State	20b. Place of D		me of	ill Rd.	Freeland		21053 City or Town, State
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permit. Pagas Department of Important: If the any Injury or o	21. Supature of Funeral Servica Lica	nseDepnis C.	Carroll	22. Name at	nd Addre	ess of Facility Ruc Rd. T	k Towson owson, M	Funera	l Home, Inc.
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cartificete ractor, pa	25. Wes case referred to medical				-	26. Place of De	ath (Check only on	Θ)	
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Attending For death. Sector: After by the funer	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation		Year) Inju	M		Yes 2 No			
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within 2 To the comple		1	0	29	c. Licen	se number	2	9d. Date signed	d (Month, Day, Year)
tig to s	Almi	honykil	leg, u						
311	30. Name and address of person who	completed cause of dea	Mn (Kem 23a) (T)	rpe, Print)	1. C	horles	9. 81	Cto. 1	26,1998 MJ 21205
State Registrar	31. Date filed (Month, Day (1937)	12 Riegisman	s Signatura						

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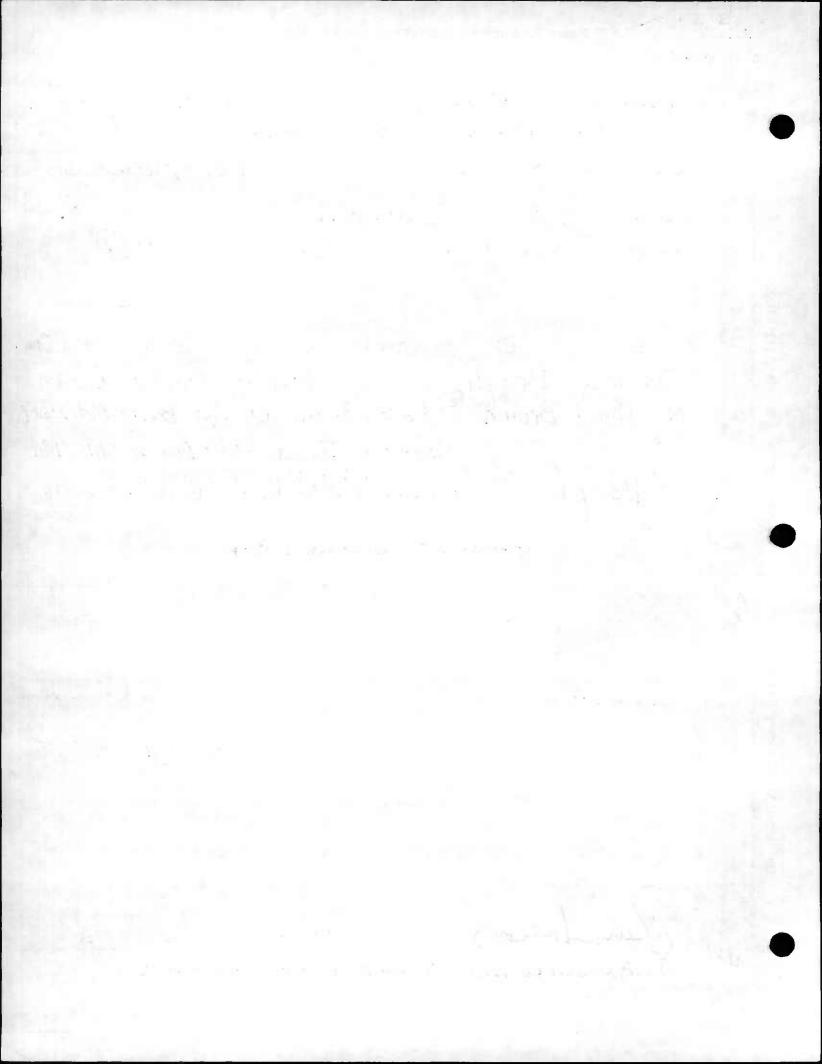
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State of Maryland / Department of Health and Mental Hygiene

CALVIN	BROWN
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C	'ALVIN E	RO	WIN	State of Maryland	Certifica			, or or near tray	Reg. No.	23	3042	
			1. Decedent's Neme (First, Middle, Las	"				2. Dete of De Month		Yeer	3. Time of I	Death
	Physici /Medic	al le	Calvin	Brown)			JULY	23, 1998		8:50	AM
	Examir	er	4e Fecility Neme (If not institution, give JOHNS HOPKINS B	street end number) AYVIEW MEDICAL	CENTER		4b. City, Town, or BALTIMO		h 4c. County	Death A		
	Funeral		Social Security Number 6. Se		st birthdey) If Und	er 1 Yeer	If Under 24 Hrs	8. Date of Bi	rth	9. Birthp	lece (Stete or	Foreign
	Funeral Director			MM 20 F 7/	Yrs. Months	Deys	Hours Min.	IVIAII	26,1921	Sout	(1/1)	olina
	ryland		10a. Sfete 10b. County	10c. City,	Town or Location					1	0d. fnside Clt	
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	with th	Dire	10e. Street end Number	acak 1.		ip Code	22/		10g. Citizen of W	het Coun	fry? }	
	ne 23	erai	7005 STIQY	12. Was Decedent Ever in U.S.	13. Wes Dec	edent of	AU Q Hispanic Origin? (S	Specify Yes or N	0- 14. Rece	- Americ	an Indien,	
0	ofter o		1 Never Married 2 Married	Armed Forces? 1 Lyes 2 □ No			Hispanic Origin? (S ean, Mexican, Puer	to Rican, etc.)		c, White,	etc.	
002	ral', c	dby	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 (25L NO	Specify:		Specify	DIC	ack	
21215-0020	pempit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, if a Medical Examines must be notified at once.	Be Completed	15. Decadent's Edi (Specify only highest gred	ucafion le completed)	16e. Decedent's Us (Give kind of k	vork done	petion du <i>ring</i> most of wo ad)	rking	16b. Kind of Bu	siness/Ind	dustry	
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ylar	Mental Merked of attic eve	10	James &	Brown			Myrt	le t	Sigby	L	Brow	n
Maryland	l 2 shd is ma raum		19e. Informent's Name/Relationship (1	ype, Print) (wife)	19b. Meiling Addre	ss (Stree	t end Number or Ri	V 1.	DI	Stete, Zip	Code)	21/
	1 and Health em 27		20e. Method of Disposition	YOWY) 20b. Plet	t み		amroc	Date /	20c. Location -	City or To	wn, Stete	206
Baltimore,	Peges nent of mrt: If its iry or o		1 ☑ Buriel 2 ☐ Cremetion 3 ☐ I	Removel from State	netery, cremetory or	other ple	ice)	7/28/98	Dulinge	M	:16 0	11
量	permit. Peg Department Important: I any injury o		21. Signature of Funeral Servica LiCens	790		and Addr	ess of Facility	-	Owings	1111	115,1	IU,_
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Ġ.	Physician		U							1	Intervel Betw Onset end D	eeth
	/Medical Examiner		tmmediate Ceuse (Finel disease or condition resulting in death)	Arteriosclero	tic Cardi	ovas	cular Di	sease				
		Te.		Due to (or e	es e consequence o	f):						
	Dente de la contente	Examiner	Sequentially list conditions	b. — Due to (or e	es e consequence o	f):				1	_	
Ó,	4	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury									
68760,	The law requires thet the death certificate be ate has been signed by the ettending physical page 2 should be detached for use as the law	edicai	thet inifieted events resulting in deeth) Last	Due to (or e	s e consequence of):						
	certifi ding	5		d								
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5	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2X EF	R/Outpetienf 3 1	OOA O	her:	eth <i>(Check only</i> Home 5 ☐ Res	one) sidence 6 □Oth	ar (Snecif	v)	
Division of Vital	g Phy er this		27. Manner of Deeth		8b. Time of Injury	28c. Inju	-	T	how injury occurr		,,	
000	Attending or death. ector: After by the fune	atio	2 ☐ Accident investigation	(monn, boy roay	М		Yes 2□No					
<u>Š</u>	ofter defined	Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injury - Af hom building, etc. (Specify)	e, farm, sfreef, fecto	ory, offica			(Street end Numb wn, Stete)	er or Rure	I Route Numi	ber,
	pital purs e erel filled	2	29s. Certifying Phy	sicien: To the best of my knowle	adan daeth courre	d at the t	imo data and along	a and due to the	a cauca(a) and ma	0001000	totod	
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	To the Hospital or Attending Physician: The law within 24 hours effect death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	Me	290. Signature end title of certifier	0 .	2	9c. Licen	se number		29d. Date signed	(Month,	Day, Year)	
	,		Mars to	hem)		0	.C.M.E		JULY	27,	1998	
	411		30. June and address of person who c		3e) (Type, Print) L Penn St	reet	, Baltimo	ore, Mar	yland 21	201		111/
	Sta Registr		31. Defe filed (Month, Day, Year)	32, Registrer's Signatur	re							

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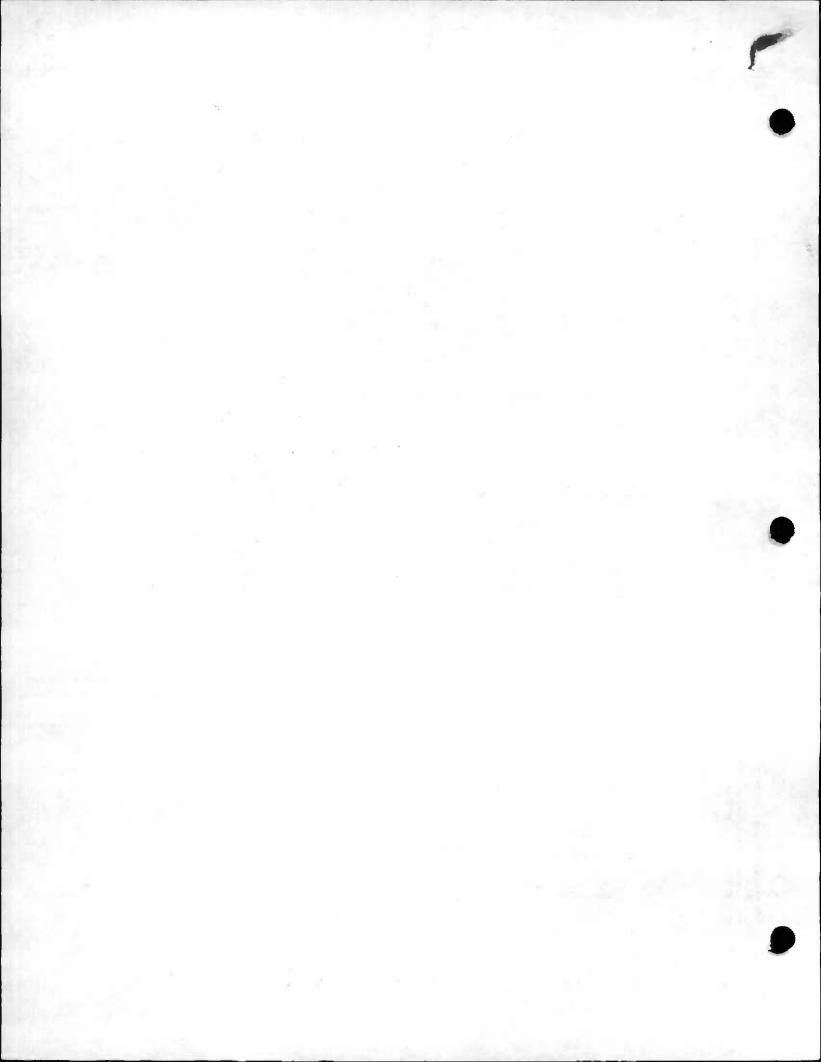


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Year **Physician** Frank E. Burnett July 25 1998 1:15 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1567 Crofton Parkway Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 21, 1 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Hours Months Yrs. 121-18-8133 **Director** New York Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Anne Arundel Maryland Crofton 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1567 Crofton Parkway 21114 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 (A)Yes 2 □ No If Yes, Give Yeer or Detes: WW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Stetus 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flam 27 is marked other than "n any injury or other traumatic avant, the Mentalone. College (1-4or 5+) Elementery/Secondary (0-12) Broker Real Estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth G. Burnett Marian P Adams 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June W. Burnett (Wife) 1567 Crofton Parkway Crofton Md. 21114 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory Inc. 7/27/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licenses 22. Name end Address of Fecility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Pert 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) RESPIRATORY ARREST Examiner Due to (or es e consequence of): Physician/Medical Examiner DLON CANCER Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) physician and P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes an eutopsy 1 ☐ Yes 2 BNo 1 ☐ Yes 2000 Division of Vital or Attending Physician: Be director 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28c. Injury et Work? 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Reture 5 Pending a Funeral Director: After detail. 1 Yes 2 No 2 Accident Investigetion 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted. within 2 To the 29b. Signeture end title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Paro 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCHELVILLE Rd POWIE, MD 20716 4201 MITI 22. Registrer's Signeture ressey acol 31. Dete filed (Month, Dey, Year) 32. State Ma Davidson

DHMH 16 Rev 6/95

Registrar

JUL 281998



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Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) JULY 24, Dey 1998 Year **Physician** TLENE **BI.ANKMAN** 4:30AM /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** 9005 SAMOSET ROAD RANDALLSTOWN BALTIMORE if Under 1 Year If Under 24 Hrs.

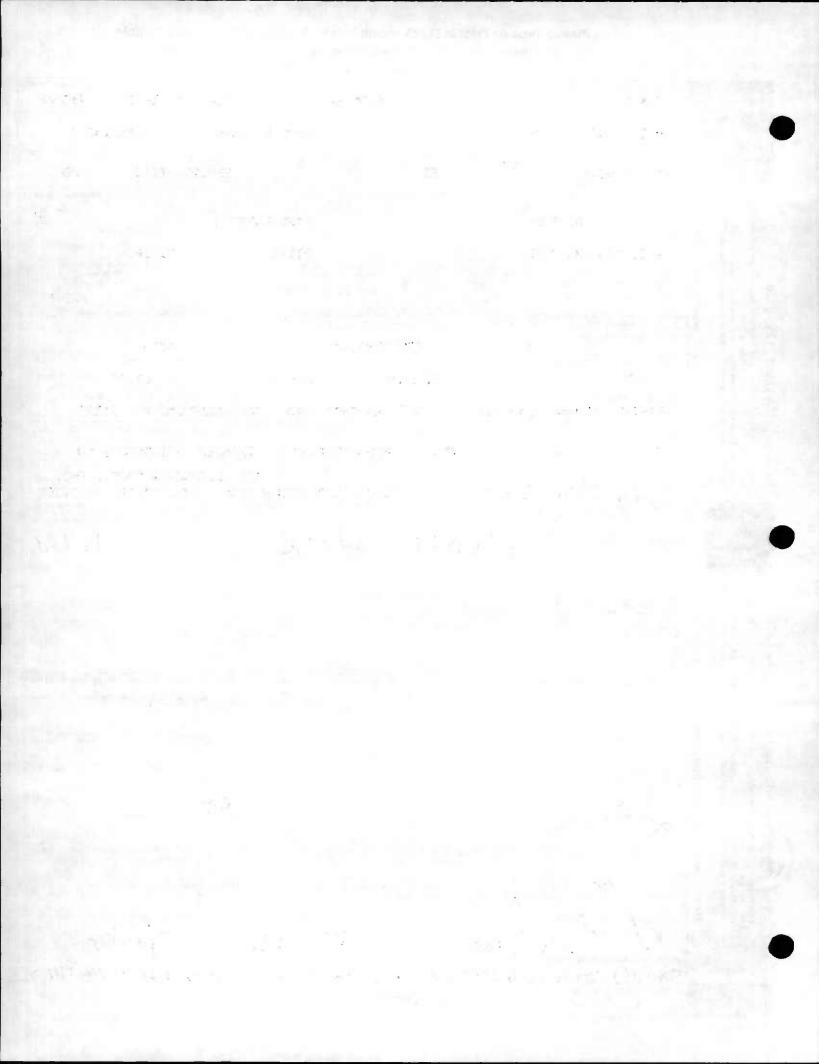
Months Devs Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 1 M ACK Yrs. Director 218-42-6676 52 FEB. 27, 1946 Usuel Residenca of Decedent with the Maryland 10d. Inside City Limits 10e. State 10b. County 10c. City, Town or Location show Item 27 is marked other than "naturel", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes artho Director MD BALTIMORE RANDALLSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9005 SAMOSET ROAD death v 21133 U.S.A. Funeral Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Exeminance. 1 Yes 2 No 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 OPTOMETRIST **EYES** 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be HENRY BLANKMAN MIRIAM BAIDER 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9005 SAMOSET ROAD MIRIAM BLANKMAN (MOTHER) RANDALLSTOWN, MD 21133 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 7/26/98 CHIZUK AMUNO ARLINGTON BALTIMORE, MD 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, sert failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Bug physician s the burial P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): 88 esn 10 signed by the eld d be deteched for 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown of Vital Records, p 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peeu page 2 1 ☐ Yes 2 ØN 1 ☐ Yes 2 ☐ No certificate affer death.

Director: After this partition funeral director, Be 25. Wes case referred to medical exeminer? 28. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home (5 ☐ Résidenca 6 ☐ Other (Specify) PE No 10 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Division Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner as stated.

I medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) and henner stated. 29e. Certifier Medicai Fur (Check only one) To the within 2 To the 29b. Signeture end title of prtifie 29c. License number 29d. Date signed (Month, Dey, Year) m) completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who HOLKERM 21 CROSPROSES OR 7415 OWENES MILLS State Registrar

Registra

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 23 part I,per M.D G-761 7/28/98 reb Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death HRISTIAN 0:0784 JUL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5 YKES VIL If Under 24 Hrs. 8. Date of I Hours Min. (Month. ARROLL ARE 3 Usual Residence of Deceder 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No MARYLAND 10e. Street and Number 10f. Zip Code g. Citizen of What Country? AVENUE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 1 Never Married 2 Married 1□ Yes 2No Specify: BLACK Specify 3 Widowed 4 □ Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OPERATOR

19b. Mailing Addrass (Street end Number or Rujal Route Number, City or Town, Stete, Zip Code)

2517 SHIRLEY AVENUE, BALTIMORE MD. 2/2/5

20b. Place of Disposition (Name of cametery, cremetory or other place)

Date

20c. Location - City or Town, State

18. Mothar's Name (First, Middle, Meiden Sumeme)

MACHINE

CHRISTIAN

16b. Kind of Business/Industry

TEXTILE

MORRIS

Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0020 Health and Mental Department of Important: If it any injury or or snot. **Physician**

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

10a, State

15. Decadent's Education (Specify only highest grade completed)

College (1-4or 5+)

31. Date filed (Month, Day, Yeer)

Elementary/Secondary (0-12)

5+4GRADE

JEFFERY

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Reflationship (Type, Print)

20a. Method of Disposition

1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State

TITEODORE CHRISTIAN

Funeral

Director

Hems 23s or 28s-f

ò

al Hygiane.

/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be asscuted within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician end completaly filled in by the inverted inector, page 2 should be deteched for use as the buniel-transit

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Lines 23a. Part1. Erger the disease, or com	9WN L	22. Name JOSE 2 14	e and Address of Facility PH H. BR O N. FULTON	7-18-98 PIKESV OWN JR. FUNE AVE. BALTIHO	=RAL HOME P.
	shock of heart feilure. List only		ath. Do not enter the r	mode of dying, such as cardi	ac or respiratory arrest,	Approximate Intervel Between Onset and Death
1	Immediate Cause (Finel disease or condition resulting in death)	Ren-	1 F	/~.2		3 411
ı		Due to	(or as a consequence	of):		
l		D. ————————————————————————————————————		UNKNOWN PRIMARY		1 Mo.
1	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consequence	of):		
	cause. Enter Underlying Cause (Disease or injury that initiated events	C				Ì
l	resulting in death) Last	Due to	(or as a consequenca	of):		
		d				1
					24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical			26. Place of De	eath (Check only one)	
	25. Was case referred to medical exeminer? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2[□ ER/Outpatient 3□			ner (Specify)
	exeminer? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)			eath (Check only one) Home 5 Residence 6 Oth 28d. Describe how injury occur	
	exeminer? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	DOA Other: 4 Nursing 28c. Injury et Work? 1 Yes 2 No	Home 5 ☐ Residence 6 ☐ Oth	rrad
	exeminer? 1 Yes 2 No 27. Menger of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifier 1 Certifying Ph	28a. Dete of Injury (Month, Dey Year) 28e. Place of Injury - At building, etc. (Special systems: To the best of my kn	28b. Time of Injury M home, farm, street, factify)	DOA Other: 4 \ \text{Aursing}	Home 5 Residence 6 Oth 28d. Describe how injury occur 281. Location (Street and Numb	ber or Rurel Route Number,

State Registrar

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Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death JULY **Physician** 28 1998 Carolyn F. Cranston 9:00 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Gilchrist Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 9. Birthplece (Stete or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M X F 213-32-2031 62 Yes Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 25a-f show pains! Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Lutherville 10f, Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 13 Seminary Drive 21093 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises page. Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 27 No 1 Yes No Specify: Baltimore, Maryland 21215-0020 White Specify: þ 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Broker Financial Planning 18 Mother's Neme (First Middle Maiden Sumeme) 17. Fether's Name (First, Middle, Last) M. Edward Saffran Hilda Novak 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Retetionship (Type, Print) Harry J. Cranston, Jr./son 9A Bee Tree Mill Ct. Parkton, MD 21120 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 7/29/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fineral Service Licens Cremation Society of Maryland, Inc. Edward A. gegorchik 299 Frederick Rd. Balti
23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 Approximate tntervet Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical cancer 1ears Examiner Due of or es e consequence of): Physician/Medical Examir Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): P.O. Box 68760 thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? TYPE 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Jarolen Changton Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate 89 25. Wes cese referred to medical 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA # 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, efc. (Specify) 4 | Homicide Funeral 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier Medical To the Ho within 24 I To the Fur 29d. Date signed (Month, Day, Year) 29b. Signeture and title of Certifier 29c. License number 30. Name and address of person who gor N. Charles St. Belto Md 21204

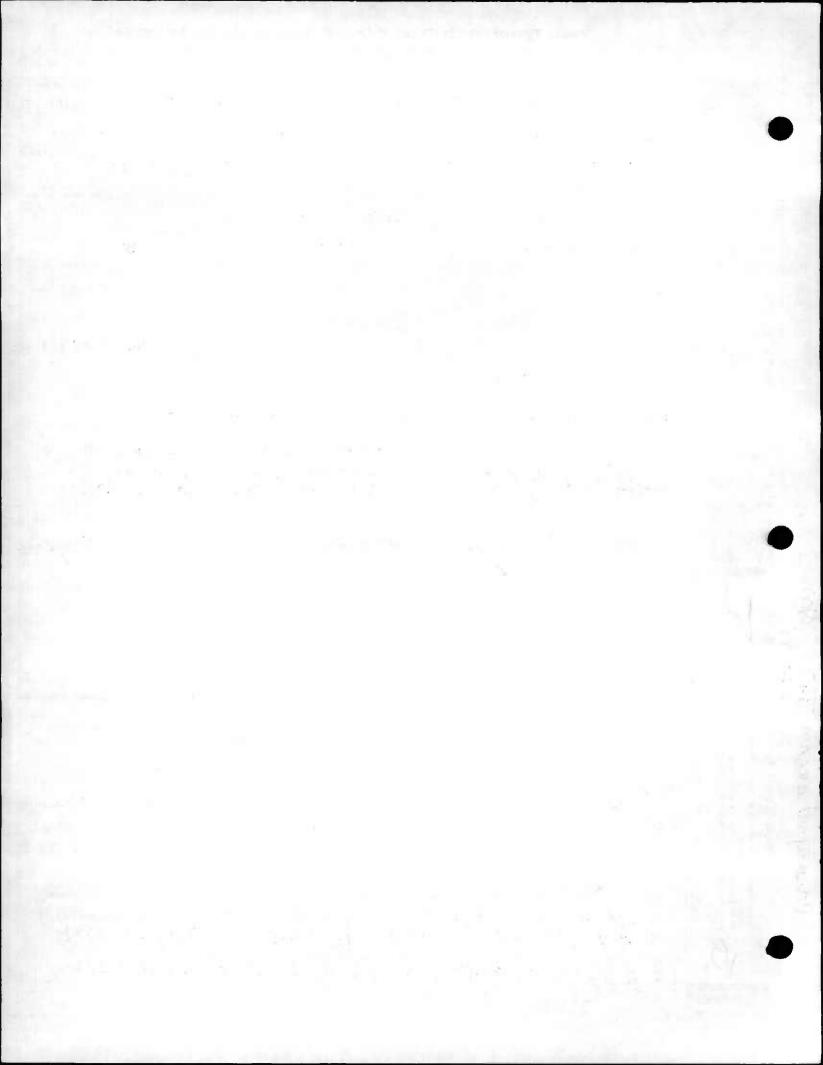
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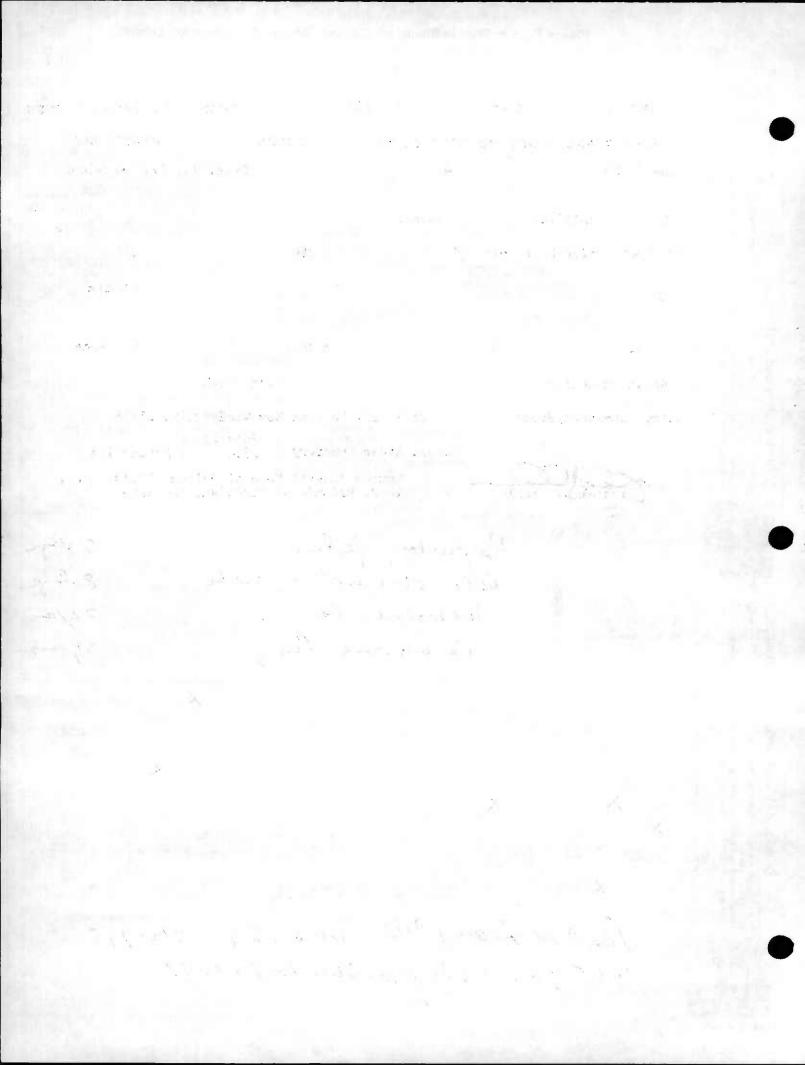


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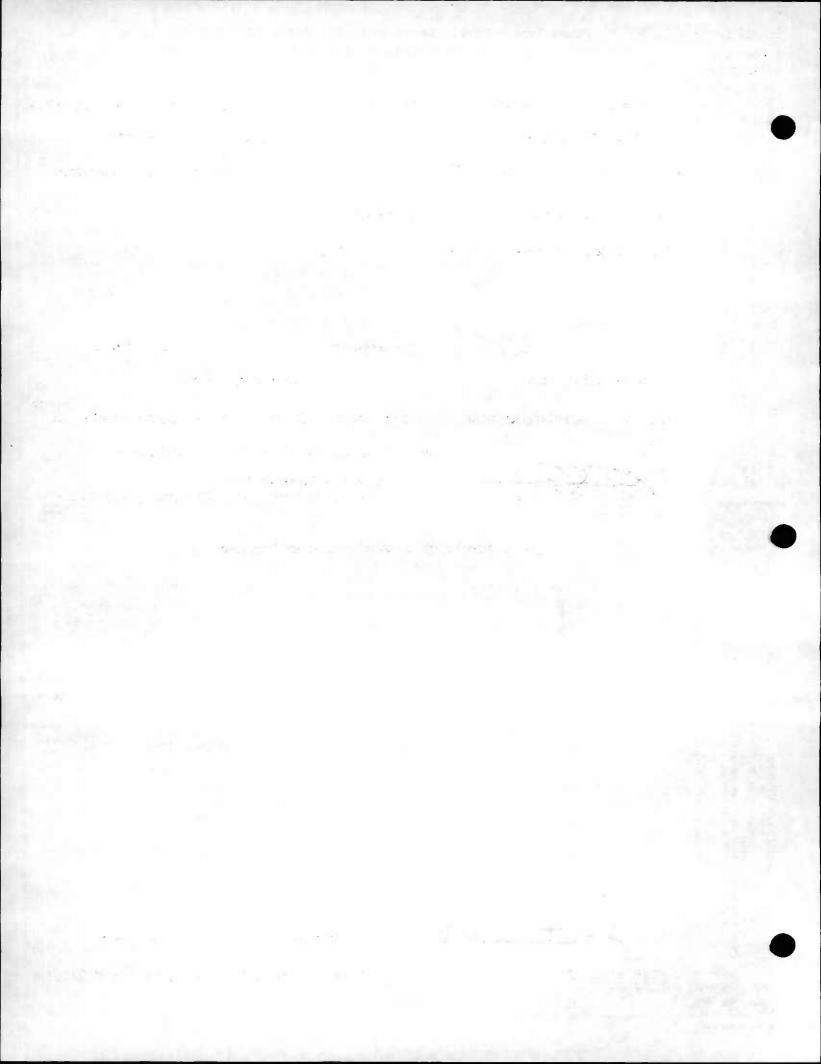
State of Maryland / Department of Health and Mental Hygiene

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State Registrar

31. Dete filed (Month, Day, Year)
JUL 281998



Physician /Medi Examir Funeral Director

1. Decedent's Name (First, Middle, Last)

Cilumbre 110, Angelo J Baltimore, Maryland 21215-0620

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death cardificate be within 24 bours after death.

To the Funeral Director. After this certificate has been signed by the attanding physician completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn

Division of Vital Records, P.O. Box 68760,

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Certificate of Death

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and 21215-0020 be filed within 72 hours after death with the Manyland tiel Hyglene. diother than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Detes:	13. Was Decedent of the Yes, specify Cub. 1 Yes 2 X No.	Hispenic Origin? (Specify pan, Mexican, Puerto Ricar Specify:	n, etc.)	4. Race - Americ Bleck, White, of Specify: Wh	
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Physician: This certific and director,	Hospital:	R/Outpatient 3□ DOA O	ther: 4 Nursing Home	5 Desidence 6	☐Other (Specif	y)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificata has complately filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Double 1 Naturel 5 Pending (Month, Dey Yaar) 2 Accident investigation	28b. Time of Injury M 28c. Injury M	ork? 28d. ⊇Yes 2 □ No	Describe how injury	occurred	
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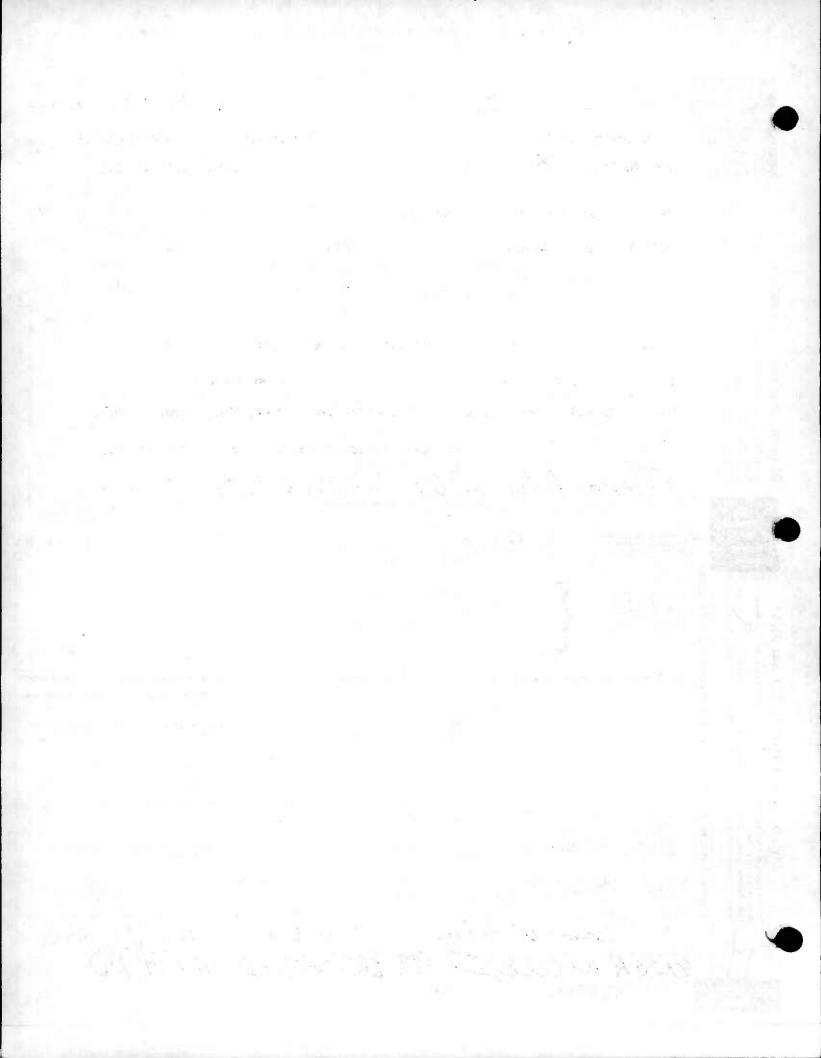
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** DELLINGER DONALD JULY 7:15 am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 5625 Dartmouth Street Churchton Anne Arundel 8. Date of Birth (Month, Dey, Year) St 5, 1932 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Days Months 1XM 2□ F 292-28-5420 65 Yrs. Director Ohio Usuel Residance of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Locetion permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryla Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at pince. 10d. Inside City Limits Director 1 Yes 20 No MD Anne Arundel Churchton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5625 Dartmouth Street 20733 USA Funeral 12. Wes Decedent Ever in U,S. Ammed Forces? 100 Ses 2 □ No If Yes, Give Yeer or Dates: 1958–62 Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, Whita, etc. 1 Never Merried 2 Married 21215-0020 White 1 Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Educetion (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) 12 Procurement Specialist Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Surname) Be 2 Robert Dellinger Aileen Unknown 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Barbara A. Dellinger - Wife 5625 Dartmouth Street, Churchton, MD 20733 20b. Plece of Disposition (Nema of cemetery, cremetery or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, Steta 1 A Burial 2 Cremation 3 Removal from Stete Maryland Veterans Cemetery 7/28 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Lice 22. Neme end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errast, shock, or haart failure. List only one cause on sech line. Approximete Intervel Batween Onset and Deeth **Physician** Immediete Ceusa (Finel disease or condition resulting In deeth) /Medical METASTATIC CANCER 14 MONTHS LUNG **Examiner** Due to (or es e consequence of): Physician/Medical Examiner sate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest end the burlat-frer Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, ettending physician Due to (or es e consequence of) The law requires that the death certiff for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown b page 2 should be 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy peed certificete has 2 X No 1 Tes 1 Yes 2 No rs effer deau...
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Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, death occurred at the time, date end place, and due to the ceusa(s) end menner steted. 29a. Cartifian Medical (Check only one) the th 29b. Signeture and per of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

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31. Date filed (Month, Day, Year) 32. Registrer's Signeture				R4 4	of N. Rec	Juced St	, APT 4	105 130	etimene MD 212	20/	
al VILWIJJO Jeme vandson-handelle			32. Registrer's	Signeture							
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1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Catherine Bernardine Donnelly 7444 24 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Oak Crest Care Center Parkville If Under 1 Year Months Devs 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. **Funeral** 1□ M 2 F Deys Hours 216-03-7010 88 Director 86/14/168 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Examiner must be notified at once. Maryland Baltimore Parkville Director 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 8832 Walther Boulevard 21234 united States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 635PM 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Lusby ပ Margaret Walsh 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bernardine Garcia / Daughter 9509 Stoneoak Road Baltimore. Maryland 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Gds. 7/27/98 Timonium, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service Licensee mais 7 9705 Belair Road Baltimore, Maryland 21236 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical METASTATIC CARCINOMA Examiner Jonne Due to (or es e consequenca of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical 2 Due to (or es a consequença of) Bernadine 100 Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. by Completed 1 Tes Division of Vital Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 2 H 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Naturel 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after deat Director: 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 24 hours To the Hospital Within 24 hours a To the Funeral C Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. edicai 29a, Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death

29c. License number

8800 WALTHER

Approximete Intervel Between Onset end Deeth 3 Weekc 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🛂 Unknown 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? NA 2000 1 ☐ Yes 2 ☐ No Other:

Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 29d. Dete signed (Month, Dey, Yeer) D45757 July 27,1998 PARKVILLE, MD 21234

3 Time of Death

9. Birthplece (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

21236

Maryland

Baltimore

Raca - American Indien, Bleck, White, etc.

Retail

White

Specify:

35 PM

State Registrar

29b. Signeture end title of cartifier

31. Dete filed (Month, Dey, Yeer)

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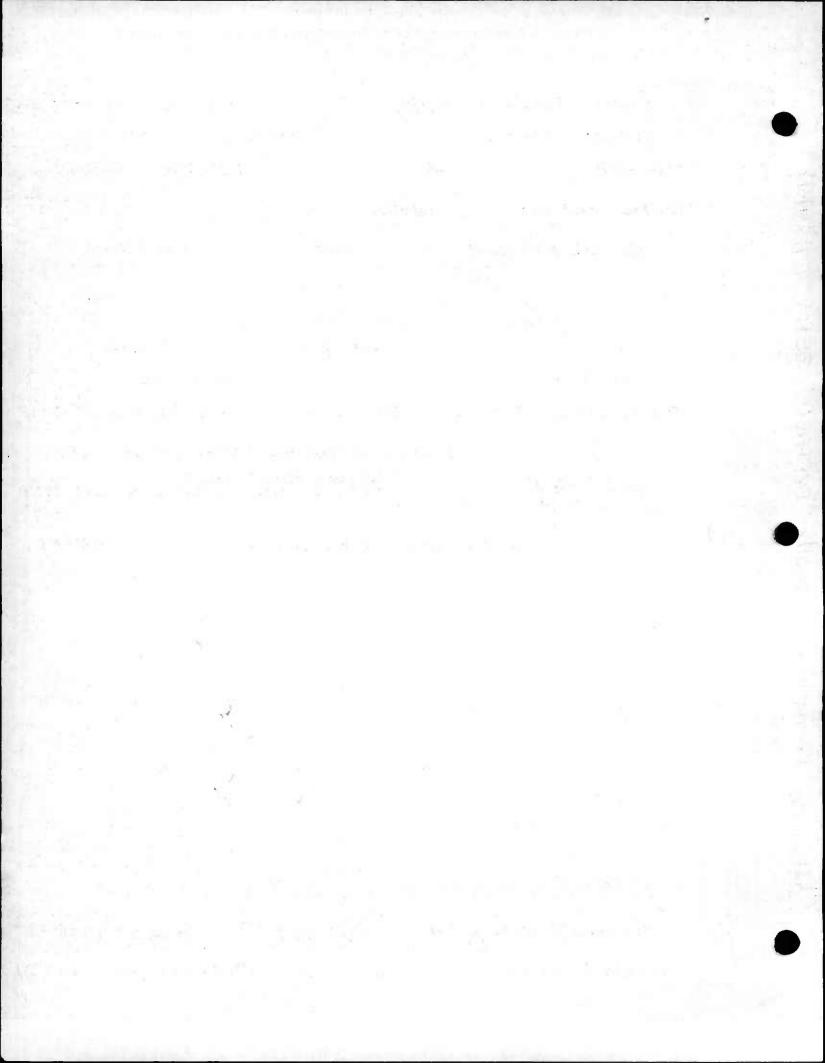
MATTHEW MICNABNEY

JUL 281998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

whie Daydon-Handell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** FRANCES tatricia 8 mi 6 July 25 1998 09:32 /Medical 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner Balt more

If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yaar) University Of malyland medical Systems 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year N/A 5. Social Sacurity Number Birthplece (Steta or Foraign
Country) **Funeral** Months Days 1 □ M 212 F 218 36 9740 Director Oct. 22, 1942 Alabama Usual Rasidance of Decedant the Maryland 10a, Stata 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f ehow Examiner must be notified at 10d. Inside City Limits 1 Yas 2 No Director Maryland Carrol1 Westminister 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? filed within 72 hours efter death with 320 Mayfield Court 21158 U.S. Funeral 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 Naver Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates: 21215-0020 "natural", or 1 ☐ Yas 2 No Specify: þ Spacify: 3 ☐ Widowad 4 🎇 Divorcad White antal Hygiene. Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Secretary Government Secretary 12th Baltimore, Maryland permit. Pages 1 end 2 should be file Depertment of Health end Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, side. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be 9 Chester Maize Frances Davis 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Kimberly Chilcoat / Daughter 1111 Gorsuch Road Westminister, Maryland 21157 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramovat from State 4 ☐ Donation 5 ☐ Othar (Spacity) 7/28/98 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway samerouske Baltimore, Md. 21225 prome 23a Part. Enter the disease of complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Let only one ceuse on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Cause (Finel disaasa or condition rasulting in daath) /Medical Atheroscherotic Coronary artery disease **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury Due to (or as a consaquance of): Box 68760, thet initieted avents rasulting in daath) Last The law requires that the death certificete the Due to (or as a consequence of). P.O. I Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown Records,

obstructive pulmonary disease

24a. Was an autopsy performad?

24b. Wera autopsy findings availabla prior to complation of ceusa of daath?

1 ☐ Yas 2 No

1 ☐ Yas 2 ☐ No

25. Was casa referred to madicat 26. Placa of Daath (Check only ona) examinar? 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Inpatiant 2 ER/Outpatiant 3 DOA 28c. Injury et Work? 27. Mannar of Death Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accidant Injury 5 Panding invastigation 1 ☐ Yas 2 ☐ No

6 Could not ba 28e. Plece of Injury - At homa, farm, straet, fectory, office building, atc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, and due to the cause(s) and mennar as steled.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stete)

29b. Signature and title of curtifier

P12417

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Nama and admass of person who complated couse of death (Itam 23a) (Typa, Print)

- MD

22 S. GTLENE STECET BOILIMOU, Marylond 21201 Hou 31. Data filed (Month, Day, Yaar)

State Registrar

32. Register's Styriature

Guna Davidson 281998

director, page 2 should

certificate hes

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of Vital

Division

or Attanding Physician:

Hospital 24 hours

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Completed

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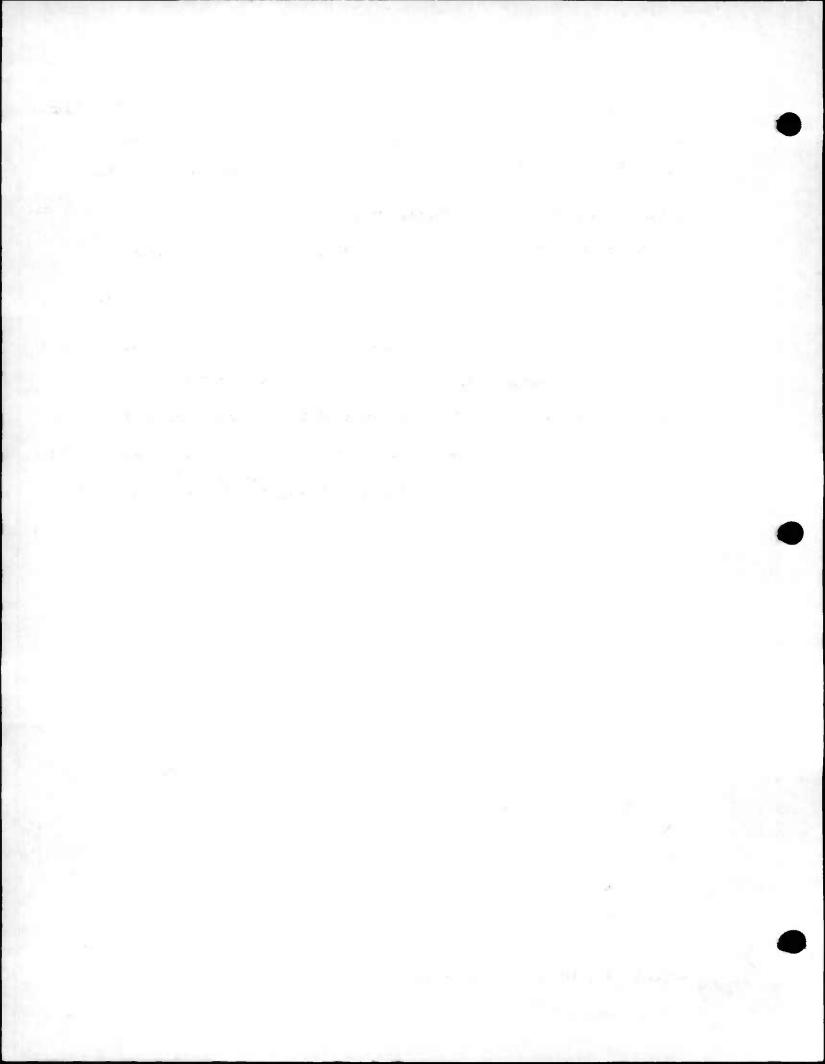
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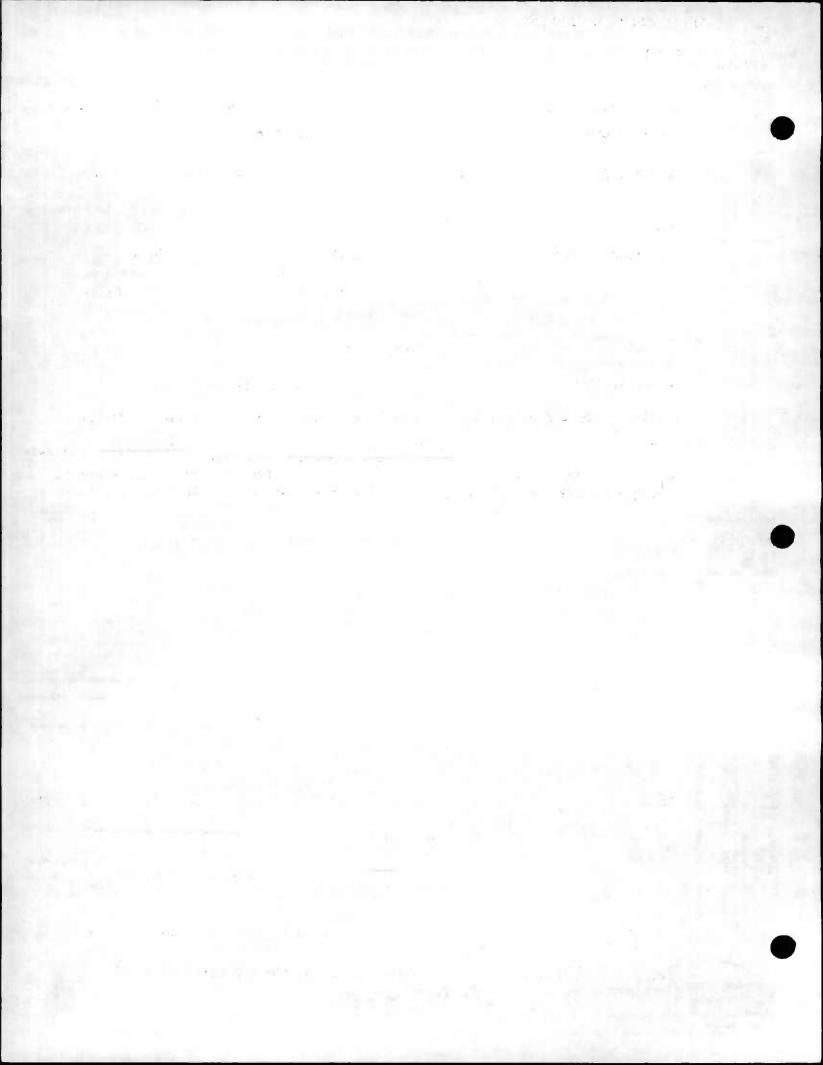
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29a, Certifier

4 Homicida



DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month JULY 28, Rexy Milton Falls 1998 1:45am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Belcamp Lorien Nursing & Rehab. Center Harford If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1□ M 2□ F 234-34-4281 89 FEB 1, 1909 West Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Belcamp 1 ☐ Yes 🎾 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 721 Sequoia Drive 21040 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Coilege (1-4or 5+) Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Alanzo Williams Rebecca Johnson 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dennis K. Falls/son 721 Sequoia Drive Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/28/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Cramation Society of Maryland, Inc. Dawn F. onalo 299 Frederick Rd. Baltimore, MD 21228 McDonald 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Yo 3 Probably 4 Unknown CUS 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy 2 XNo 1 □ Yes 2 □ No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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10a. Stete

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Manylend Depertment of Heelih end Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other thanmalic event, The Medical Exertimet mat be notified at

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at

ettending physicie for use es the bur s certificate hes been signed by the e lirector, page 2 should be detached f this

Physician/Medical Examiner

þ

Completed

Be

2

Certification:

icai

27. Manner of Death

1 Natural 2 Accident

3 Sulcide

29a. Certifier

4 - Homicide

(NO A

31. Date filed (Month, Day, Your)

5 Pending investigation

6 Could not be determined

PW

The law requires that the death certificate by or Attending Physician: funeral director, After deeth.

Division of Vital Records, P.O. Box 68760 To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: Al completely filled in by the fo

State Registrar

1 Xcertifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medicai Exa 29b. Signaturi and 29d. Date signed (Month, Day, Year) e-Ef certifie 29c. License number

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes

ompleted cause of death (Item 23e) (Type, Print) 30. Name end address of person who

EILIU

28e. Dete of Injury (Month, Day Year)

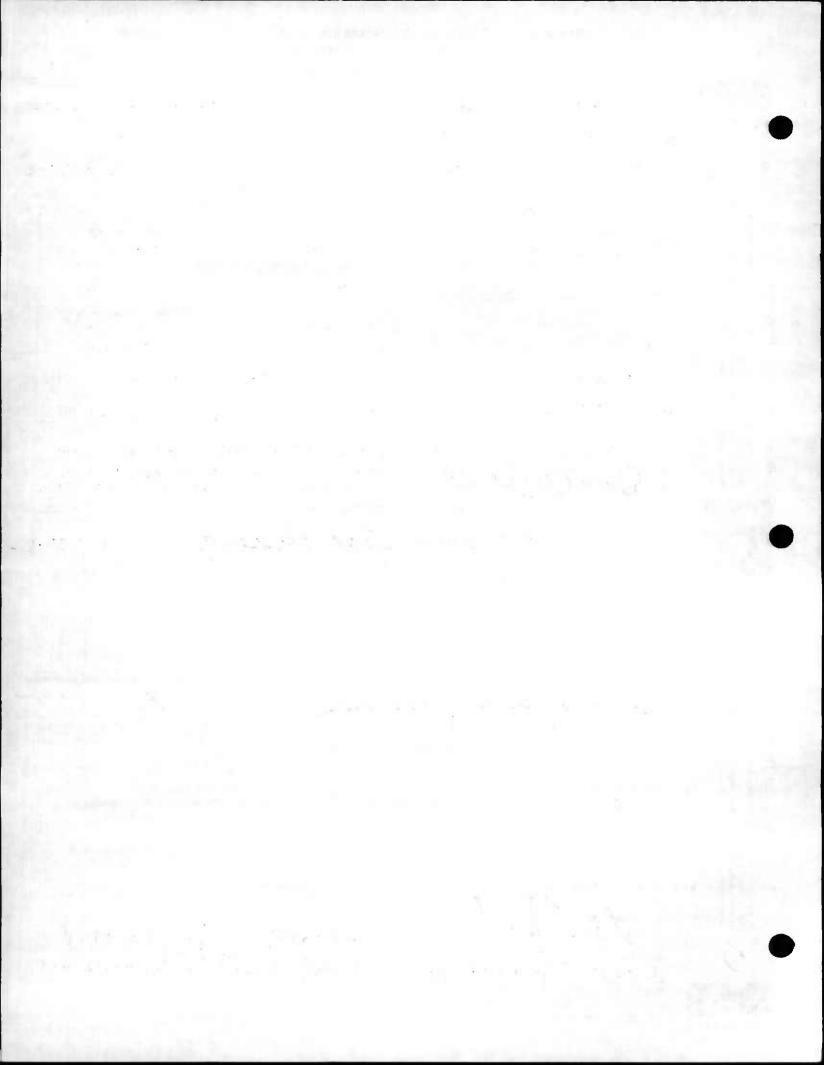
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28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrar's Signature

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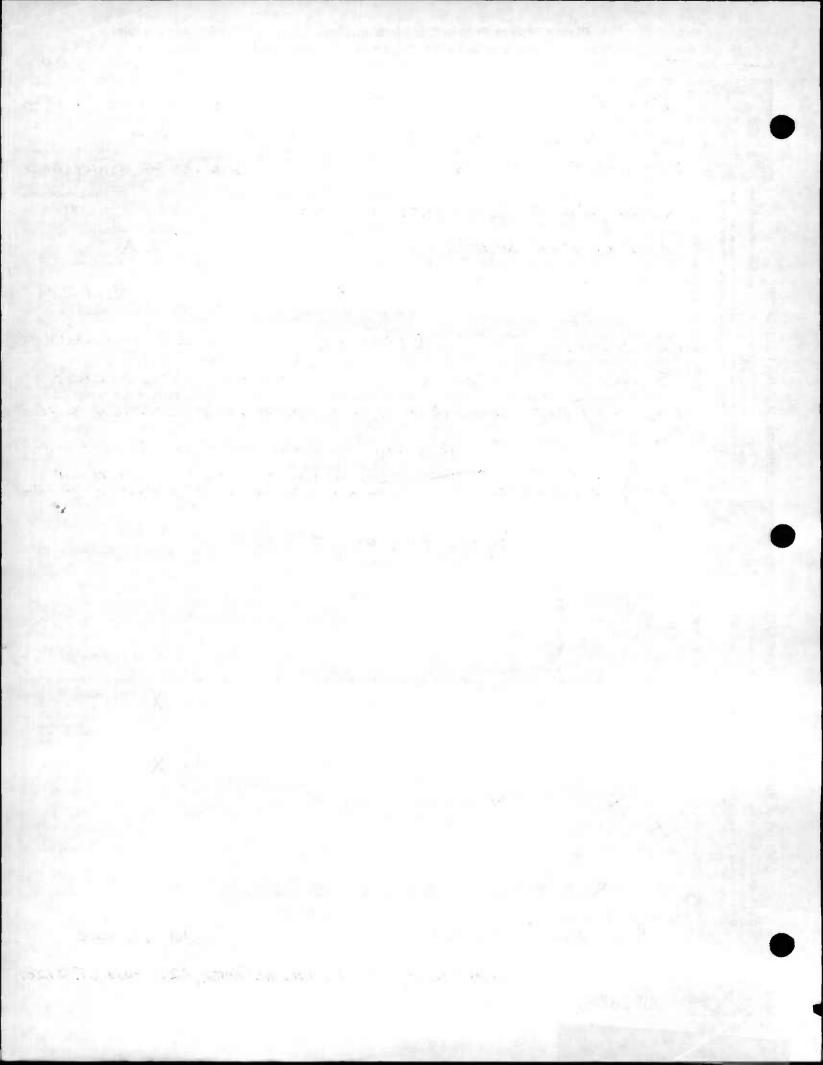
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State of Maryland / Department of Health and Mental Hygiene 98 23058

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BALTIME	or Location of Deeth	1.10	of Deeth					
1 Yeer If Under 24 I		NIA	Birthplece (State or Foreign Country)					
220-64-8043 1 M 28 F 44 Yrs. Months Deys Hours Min. (Month, Dey, Yeer)								
Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location								
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Code 1215		10g. Citizen of Whet Country?						
fent of Hispenic Origin? ify Cuben, Mexicen, Po 2 M No Specify:	14. Race - American Indian, Black, White, etc. Specify: BLACK							
ol Occupetion rk done during most of	working	16b. Kind of Bu	siness/Industry					
se retired)	INSURANCE COMPAN							
.AL								
		Hauntler OY						
19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Ste LASHALON ALFORD DAUGHTER 1407 BRISTOL TRACE, ALPHARETTA, (
20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) ARBUTUS Namerical Park 7-25-98 ARBUTUS,								
d Address of Fecility PH H. BRC I. FULTON	AVE, BAL	FUNER	AL HOME MARYLAND 2121					
e of dying, such es cer-			Approximete Intervel Between					
shock, or heert failure. List only one cause on each line.								
Immediate Ceuse (Final disease or condition resulting in deeth) e. Mycosis Fungoides								
es e consequence of):								
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euse given in Pert I.	23b. Dld	Did tobacco use contribute to the cause of death						
	10	☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknow						
24e. Wes e perfor								
		omed?	24b. Were eutopsy findings eveilable prior to completion of ceuse					
		V	of deeth?					
	10	Yes 2 No	1 ☐ Yes 2 ☐ No					
Other:	Deeth (Check only							
*Undising Notice 5 - Aesidence 6 - Other (Specify)								
8c. Injury et Work?	200. Describe	scribe how injury occurred ation (Street and Number or Rural Route Number,						
	28f Location /							
r, office		on (Street and Number of Hurel Houte Number, * Town, State)						
29a. Certifier (Check only one) Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted. Check only one) Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner esteted.								
. License number		29d. Date signer	(Month, Dev. Year)					
D . 11111	7	29d. Date signed (Month, Dey, Year)						
7-1141	/	July LL	1778					
	1	1						
D. HEDICA	-L GNIER,	225. G	EEN ST. 21201					
in	my opinion, deeth	the time, date and place, end due to the my opinion, deeth occurred at the time, icense number.	the time, date and place, end due to the ceuse(s) end me my opinion, deeth occurred at the time, date end place, e					

DHMH 16 Rev 6/95

Registrar



29c. License number

Sinai Hospital of Baltimore

4c. County of Death Baltimore Birthplece (State or Foreign Country) MARCH 28, 1921 SOUTH CAPOLINA 10d. Inside City Limits 1 Yes 2 No 10a. Citizen of Whet Country? USA. 14. Reca - American Indian, Black, White, etc. Specity: BLACK 16b. Kind of Business/Industry LAUNDRO MAT 7-30-98 ARBUTUS, MARYLAND 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? No No 1 Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end manner steted. 29d. Dete signed (Month, Day, Year) AS 2402321-KB9171 24

3. Time of Deeth

Hospital

State Registrar

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edical

29a. Certifier

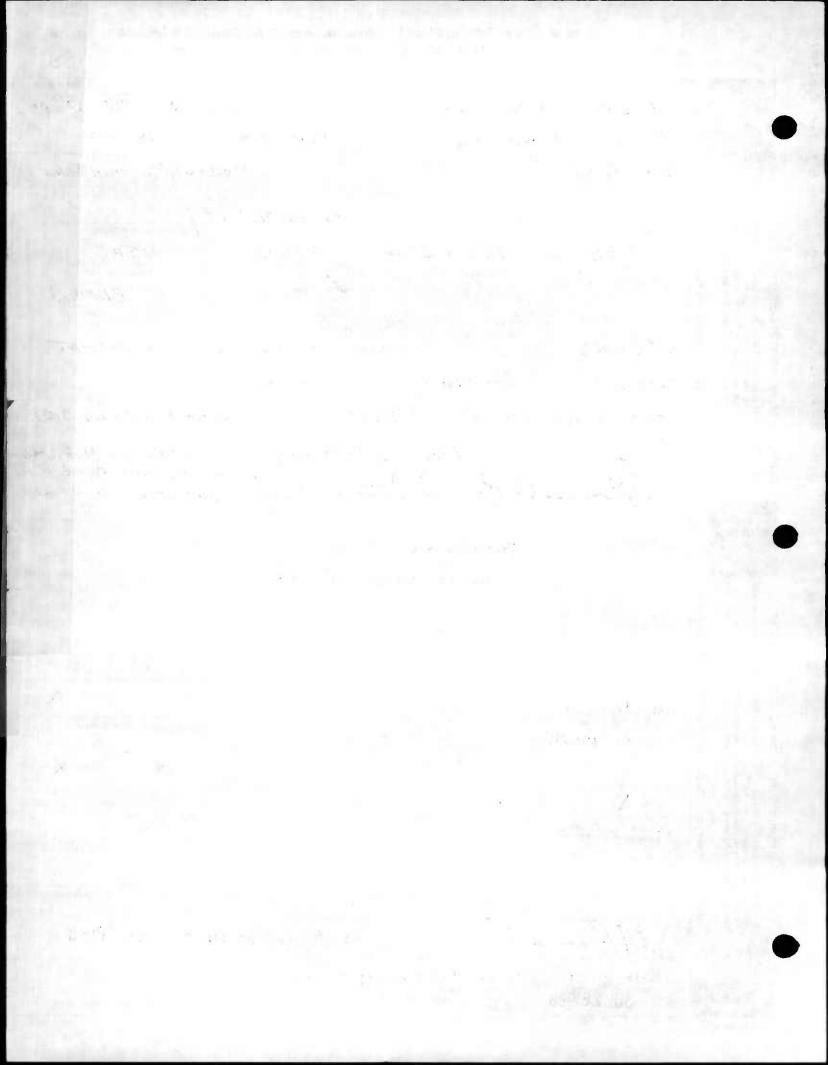
31. Dete filed (Month,

29b. Signature and title of certifier

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Barnard

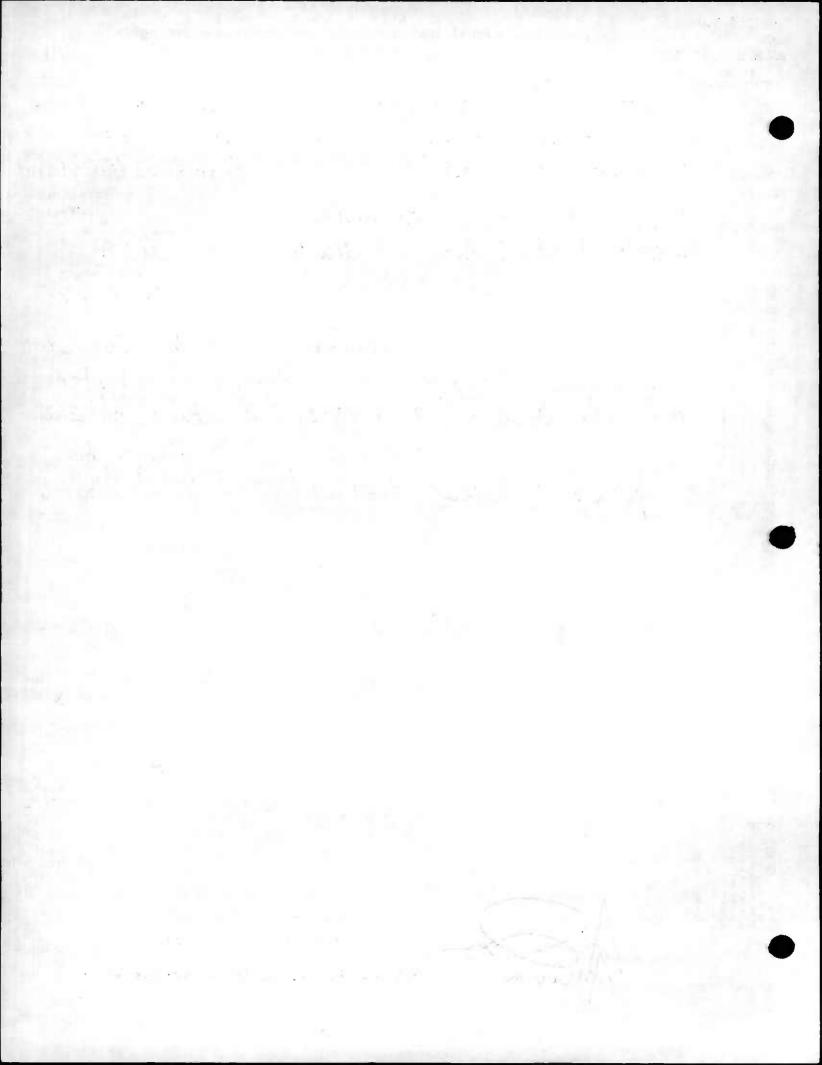
32 Agaistrages Signature Andrew



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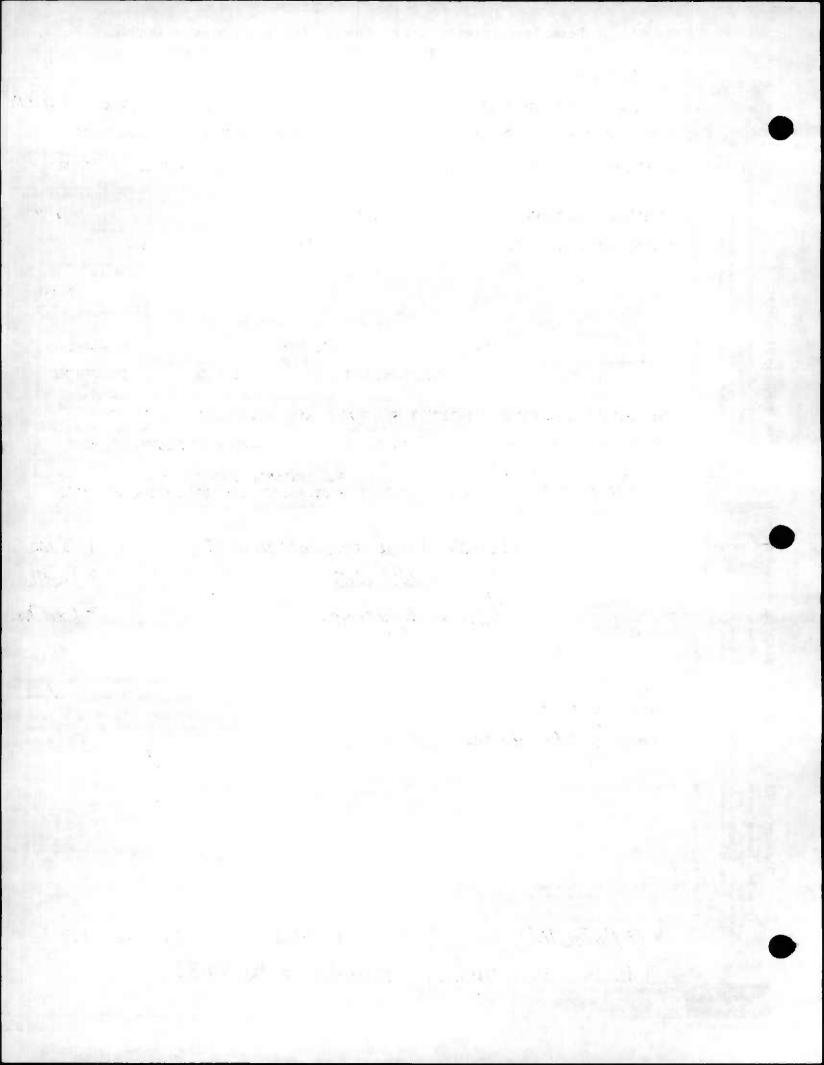
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	ITEMS: #	23	PART I, 27, 28 1. Decedent's Name (Fi		MEO G761 7-29-98	WR. Certifica	ile oi	Deam	2. Dete of De	Reg. No.	3	Time of Deeth	
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X	Examir	er	4a Fecility Name (If not			_		4b. City, Town, or L		h 4c. County	of Deethy A		
					JE-VACANT HOUS		er 1 Year	BALT'IMORI		rth	O Pirtheless	(State or Foreign	
	Funeral Director		5. Sociel Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthdey) Yrs. ### Hunder 1 Year If Under 1 Year Months Deys Hours Usuel Residence of Decedent						8. Date of Bi	5,1953	Mar	(State or Foreign	
	dand dand											nside City Limits	
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	th with	alD	2827	Wald	lorf Aue		212	15		U:	SA		
	dea	Funeral	11. Marital Stetus		1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ N			nt of Hispenic Origin? (Specify Yes or Ny Cuban, Mexican, Puerto Ricen, etc.)		No- 14. Race - Americen Indian, Black, White, etc.			
21215-0020	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 3 Widowed 4							Afri-American			
5-	72 h	Completed		Decedent's Edu				during most of wor	king	16b. Kind of Bu	islness/Industr	у	
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Maryland	ontal	Be c	101110	WCO	Genra	0		Alo	0.10	Pain	dovt	or	
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M	nd 2 s		Mrs Ale	an G	and Man	2827	Wal	dorf,	Ave. 7	Balto	Md.	2/2/5	
re,	E Had		20a. Method of Disposit	ion	20b. F	Plece of Disposition (A	leme of	00)	/ Date/	20c. Location -	City or Town,	State	
Baltimore	artment of pertant: If injury or		1 Burial 2 Cr 4 Donation 5		demoval from State	Arbut	US		131/98	Balt	0. N	1d.	
Ball	Depart Import Import any in		21. Signature of Funera	Service Licens	D (D)	22. Name Jo Se	and Addre	ss of Facility	s Fu	neral	Hon	ie .	
_			John	DW d	russ	2222	W.	North	Aue. J	Balto. N	Nd. 2	1216	
В			23a. Past V. Enter the A styook, or heart for	sease, or comp lure. List only o	sations that caused the deet	h. Do not enter the m	ode of dyi	ng, such es cerdiad	or respiretory	arrest,	Inte	proximete erval Between set end Death	
	Physician /Medical		Immediate Ceuse (Fina	i	NARCOTIC INTOXICATION								
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		ner			0) 01 900	r as e consequence o	11).						
Ć,	ficata be executed physician and as the bunal-transit	Examiner	Sequentially list condition if any, leeding to immerceuse. Enter Underlyin Ceuse (Disease or injure)	ons, diate	bDue to (or as e consequence of):								
68760	cata be ex physician s the buria	edical	that initiated events	ÿ	c. Due to (o	r as e consequence o	f):						
_			resulting in deeth) Last										
Вох	ath certi	lan			d								
	the all	Physician/M	Pert II. Other significan	t conditions co	ntributing to death but not res	23b. Did tobacco use contribute to the ca			cause of death?				
P.O.	ires that the de signed by the d be detached	y Ph							1	Yee 2□ No	3 Probabi	y 4 Unknown	
Division of Vital Records,	been	e Completed by								s en eutopsy omed?	eveilab	autopsy findings ole prior to ation of ceuse	
Re	The law ate has b page 2 s								es 2□ No				
tal	dclan: The certificate rector, pag		25. Was cese referred to	to medical				26. Plece of Dea					
>		To Be	exa <i>m</i> iner? 1 ☑ Yes 2 ☐ No		Hospital: 1 Inpatient 2	ER/Outpatient 3□	DOA Ot	hor:		sidence 6 🖾 Oth	er (Specify) A	T SCENE	
10	g Physer this seral d		27. Manner of Deeth		28e. Date of Injury	28b. Time of A	28c. Inju			how injury occur			
ior	Attending or deeth.	atlo	2 Accident	Pending investigation	FULLNIS / - 2/1 - QQ FETTINITO ALV				UNKNOWN				
ivis	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)						28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3124 OAKFORD AVE.				
Ω	oltal o urs el rrai D												
	Hospital 24 hours e Funeral Dietely filled	edical	29a. Certifier 1□ (Check only 2□	Certifying Phy Medical Exam	raician: To the best of my kno iner. On the basis of examina and the per stated.	wledge, deeth occurre tion and/or investigeti	on, in my	me, dete and place opinion, deeth occu	rred at the time	, date end plece,	end due to the	3. ceuse(s)	
	To the Hospital or Attending F within 24 hours effer deeth. To the Funeral Director: After completely filled in by the funer	Me	A 312/60.					se number		29d. Date signed (Month, Day, Year)			
	, >-0		> /	1	1	O.C.M.E				JULY 25, 1998			
			30. Name and address	propertion who o	counted cause of deeth (Iter	n 23e) (Type, Print)	<u> </u>				, 1000		
			1/	midi	XON	111 Penn	Str	eet, Balt	imore,	Maryland	21201		
	Sta	ite	31. Date filed (Morth, 2	Year)	32. Registrar's Signi	andson-Rand	10						
	Regist	ar	77	1111 281	998	med arous - Marky			1				



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Ιte	m#1	6b per FH G761 7/28/9	B EW		Certific	cate of	Death		Reg. No.	6	1000	
Physici /Medi	an	1. Decedent's Nama (First, Middla, Last) Sidney Goldscheider						July	July 26 1		3. Time of Deeth	
Examir		4a Facility Nama (Innot institution, giva street and number) NORTHWEST HOSPITAL CENTER					4b. City, Town, or Location of Deat RANDALLSTOWN			th 4c. County of Death BALTIMORE		
Funeral Director		5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 1214–12–0322 12 4 78 Yrs.			Mo	Indar 1 Yaar onths Days	If Undar 24 Hrs. Hours Min.	8. Data of Birt Month, Day MAR	27,1920	9. Birthplaca (Stata or Foraign Country) MARYLAND		
and **		Usuel Residence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location							1	0d. Insida City Limits		
Maryf	ğ	MARYLAND BALTI	MORE		BA	LTIMO	4 🗆 Voc. 0 🗆 No.					
n with the 3a or 28a	al Director					10f. Zip Coda 21208				10g. Citizan of What Country? USA		
The Har d	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	Armad Forcas	1 □ Yas 2X No			s Decedant of Hispanlc Orlgin? (Specify Yas or Nas, specify Cuban, Maxican, Puerto Ricen, atc.) Yas 2□XNo Specify:			o- 14. Race - Americen Indian, Black, White, atc. Specify: WH		
21215-0020 within 72 hours af giene. r then "natural; or the matural; or the matural or the matu	Completed	15. Decedent's E (Spacify only highast gr Elamantary/Secondary (0-12)	ada complatad) Collaga (1-4ol	complated) (Giva kind lifa. DO N			's Usual Occupation d of work dona during most of working NOT usa ratired)		16b. Kind of Business/Industry			
	Be	17. Fathar's Nama (First, Middla, Last)				ATTORNEY 18. Mothar's Nama (First, Middla ESTHER						
Maryland od 2 should be flight and Mental Hy 27 is merked other traumetic event	To	19a. Informant's Name/Ralationship		TATW)			and Numbar or Ru					
Baltimore, armit. Pages 1 an Department of Heal moortant: If item 2 my Injury or other ance.		MRS. SYLVIA GOLDSCHEIDER (WIFE) 1 SLADE AVE, APT. 201 BALTIMORE, MD 21208 20a. Mathod of Disposition 1 Surial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify) 20b. Pleas of Disposition (Nama of camelery, cramatory or other place) BETH JACOB 7-27-1998 FINKSBURG, MD										
Physician /Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caus ona causa on aech	iine.	8900	SOL REIS		ROAD BAI	LTIMORE	, MD	21208 Approximete Intarval Batween Onsat and Daath	
Box 68760, seth certificate be executed attending physician and for use as the burishtraneit	n/Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to Immediata ceuse. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in death) Last	0/	Dua to (d	or as a consequence	e of): tate e of): oma					> Imonth > 6 months	
by the darked	Physician/	Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributing to death but not resulting in the underlying ceuse given in Pert I.								the cause of death'		
Records, e law requires the has been signed by 2 should be demonstrated by	Completed by	Coronary arte		2			performed? avail comport da		are eutopsy findings allabla prior to mplation of ceusa daath?			
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Of Physic or rai dire	. To	1 ☐ Yas 2℃No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spec							(y)		
Vision Attending is reastly.	Certification:	1 Natural 5 Panding 2 Accident invastigation 3 Suicida 6 Could not	on he		Injury N	Work? M 1 Yas 2 No						
DIV A safter of a library	Certif	4 ☐ Homicida datamine	208. FIECE OF I	28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)				28f. Location (Streat and Number or Rural Route Nu City or Town, Stata)			ar riodie radiiber,	
- Hospin 24 hour Funeralistely fill	edical											
To the	Me	29b. Signature and titia of certifier				29c. Licansa number			29d. Data signed (Month, Day, Year)			
0,		Boston MD				D28462 July 26			26	1998		
10	- 1	30. Nema and addrass of person who	complated causa of	daath (Itar	n 23a) (Type, Print)	1 11	1 10	1 1110	10			

Randallstown Md 21133 J Boston
31. Data filed (Month, Day, Year)
JUL 281998 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 3:10Am Clizella 98 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Franklin Woods Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Funeral 1 M XXF Deys Hours Months Director 241-30-5030 75 JAN 29 1923 NORTH CAROLINA Usuel Residence of Decedent the Marylend 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2X No MARYLAND HARFORD **JOPPA** Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 602 SUGARHILL ROAD 21085 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø Yo If Yes, Give Year or Dates: Wes Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mentel Hygiene. Important: if itam 27 is marked other than "netures", or iten any julyry or other traumetic event, the traumetic page. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) FOSTER PARENT CHILD CARE 11th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be OLANDIS SANDERS 2 PENNY EVANS 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 109 W. Bayview Avenue, Pleasantville, N.J. 08232 Rev. Latta A. Hall/Husband 20b. Pleca of Disposition (Neme of cemetery, cremetory or other p. 20a. Method of Disposition Dete 20c. Location - City or Town, Stete EBERNEZER CHURCH CEMETERY 8-1-98 JOPPATOWNE, MARYLAND **XXX**Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licent 22. Name end Address of Facility WILLIAM C BROWN COMMUNITY F/H 10 1206 W. NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Meker trulic breas & Immediate Ceuse (Final disease or condition resulting in death) /Medical 3 years Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 that initiated events resulting in deeth) Last Due to (or es e consequence of) signed by the a ld be deteched f Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown þ cate has been sig r, page 2 should b 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 TYPS TITNO 1 Yes 2 HK6 certificate Attending Physician: director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Noticing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ne 10 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident or Attendent efter deat Director: 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) in by 4 Homicide 24 hours e Hospital 1 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated. edical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MYO THANT 6830 HOSPITALDRIVE BALTU

32. Solistrar's Signature

Suha Dandson-Randson

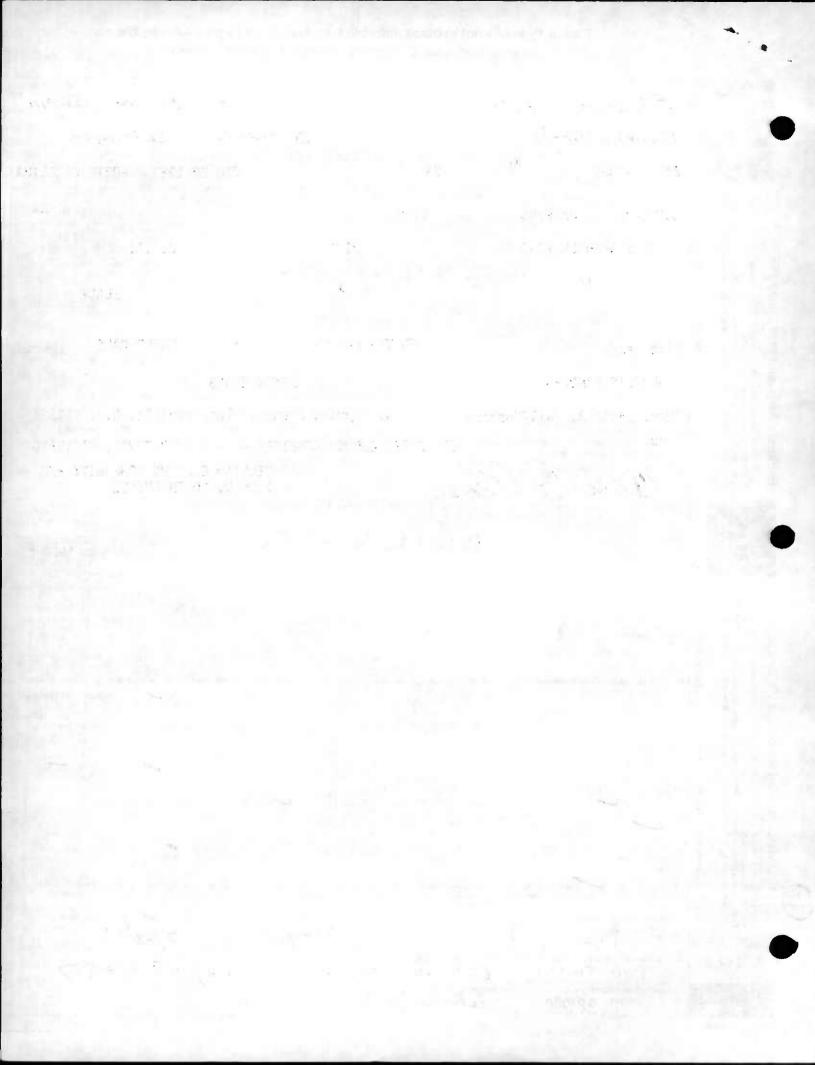
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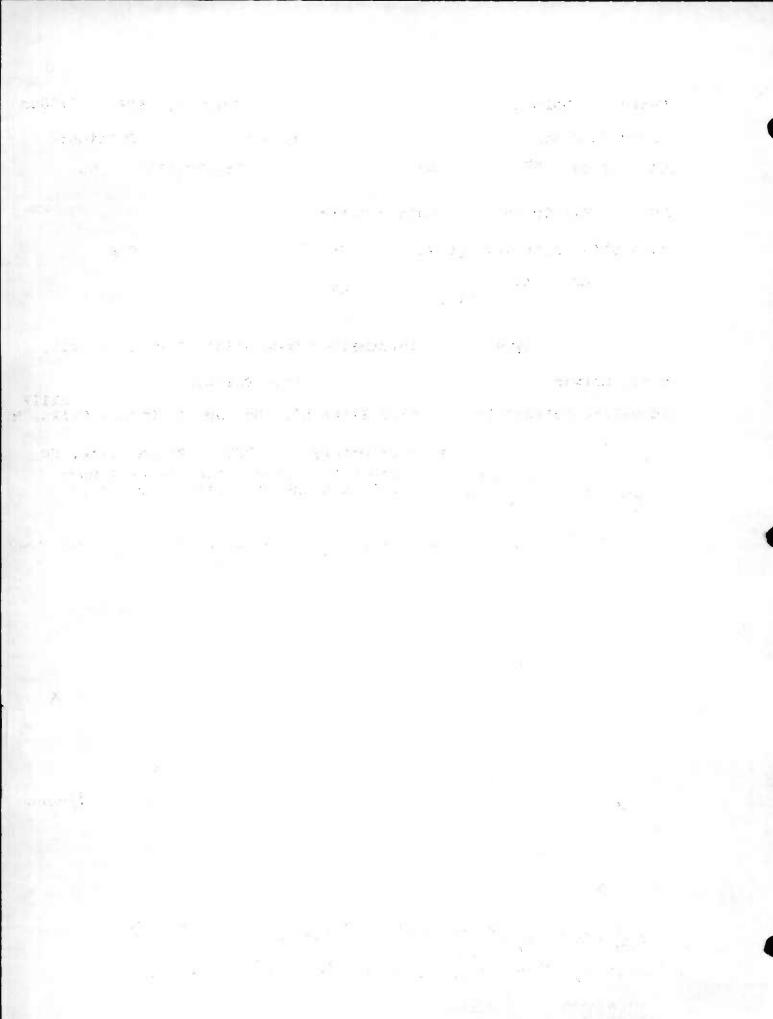
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** July 24, 5:50pm Henry Holman 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Gilchrist Center Towson **Baltimore** If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yaar) 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year Birthplace (Stete or Foreign Country) 6. Sex **Funeral** Hours Days 150 K 2 F Months 56 Yrs. Director 220-36-6484 Aug.30,1941 MD Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Show r than "natural", or items 23a or 28a-f show 1 Yes XXNo MD **Baltimore** Owings Mills Director 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 4315 Flint Hill Dr. Apt.4c 21117 USA death Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XX Yes 2 No
If Yes, Give
Year or Date Viet filed within 72 hours after 1 Never Married Married altimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes XXNo Specify. þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedent's Education (Specify only highast greda complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 4yrs. Information Specialist Social Security 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) Pages 1 and 2 should be fill the fill t Be Henry Holman Inez Hampton 19b. Mailing Address (Straet end Number or Rurel Route Number, City or Town, Steta, Zip Coda) 21117 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 Jacqueline Holman/wife 4315 Flint Hill Dr. apt.4C Owings Mills, MD 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date b 1 ☐ Burial 2 XX emation 3 ☐ Removal from State / Injury 4 ☐ Donation 5 ☐ Other (Spacify) **Metro Crematory** 7/29 Catonsville, MD of Funeral Service Licensee James A. Morton & Sons Funeral Home 5 1701 Laurens St. Balto., MD Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final · Adenocavcinoma disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): end Division of Vital Records, P.O. Box 68760, physician Physician/Medicai Due to (or as e consequence of): the use es for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 X No 1 Yes 1 ☐ Yes 2 ☐ No director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yaar) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel
2 ☐ Accident al or Attending s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) A 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature end title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) N. Charles St. Balto and 21204 Riley GBMC 6701 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature State Julia Davidson-Randall Registrar 281998

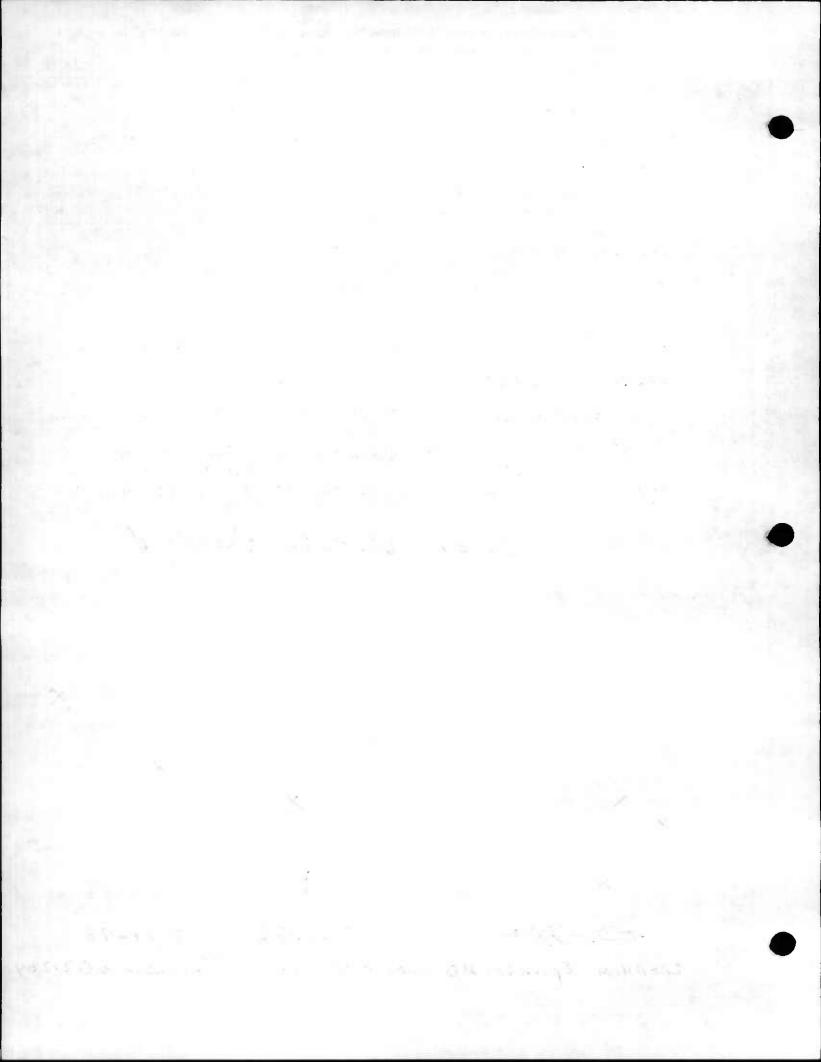
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Day Yee **Physician** 9:30 pm JANE R. HALBERT 1998 JIII. V 23 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** LUTHERVILLE STELLA MARIS BALTIMORE If Under 24 Hrs. Hours Min. Birthplece (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) **Funeral** Months 1 ☐ M 2 🖫 F 216-12-7757 Yrs Director 84 2/5/14 MARYLAND Usual Residence of Decedent tha Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Mexical Exercises must be notified at 1 Yes 2 No Directo MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2026 WESTERN RUN ROAD 21030 USA Funeral deeth 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. i flygiene. other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE US GOVERNMENT 12TH parmit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If item 27 is merked oth any lujury or other treumetic event Dice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be To HERSCHEL O. HALBERT ROSALIE BUCK 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21030 19e. Informant's Name/Relationship (Type, Print) 2026 WESTERN RUN ROAD COCKEYSVILLE, MD DAVID PINDELL/COUSIN 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State 4 Donation INC 17/29/98 5 Other (Specify) METRO CREMATORY, CATONSVILLE 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility JOHNSON FUNERAL HOME 10. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 di nv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** cerebro Vascula Acuded Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical that initiated events resulting in death) Lest Due to (or as a consequence of): attending p for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown Records, by should be 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24a. Was an eutopsy Completed peen 20 No 1 Yes 1 TYes 2 No Division of Vital Be 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Naturel Certification: 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ofter death 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours el Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signature and title-of 29c. License number 29d. Date signed (Month, Dey, Year) D25686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 OSUER DRIVE, BALTIMON MOZIZOY EBRAHIM PAKEHI MD 31. Date filed (Month, Day 32. Registre's Signature £281998 State whia Davidson-Randall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Vernel1 Jones July 24 1198 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Hospital Bultimore Baltimore If Under 1 Year Months Deys If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

Feb. 12, 1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Country) **Funeral** 10 M 2□ F Months 44 Yrs. 215-60-5069 Director Usuel Residence of Decedent 10c. City, Town or Location ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director XXYes 2 □ No MD n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5603 Norwood Ave. 21207 USA filed within 72 hours efter death v Hygiene. other than "natural", or Items 23 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 2 3 o If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify. þ 3 ☐ Widowed 4 ☐ Pivorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) Delivery Person Food Market Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be end Mantal marked Harry Jones Annie Montgomery other traumatic 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Itam 27 is Harry Jones/father 5603 Norwood Ave. Balto., MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Depertment of H Important: if Itel any injury or ott once. Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/1 Western Star Baltimore, MD signature of Funeral Service Licensee James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical 3 hrs himorrhage **Examiner** Due to (or es e consequence of): Examine LSophagral
Due to (or es e consequence of): Varices years The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest attending physician and for use as the bunal-tran Box 68760, circhosis Physician/Medicai Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 2 σ. 1 | Yes 2 No 3 | Probably 4 | Unknown ð sete hes been sig page 2 should b Completed 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? cartificate hes 1 Yes 2 No 1 Yes 2 No of Vital Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) exeminer? 1 ✓ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this funaral 27. Manner of Death 28c. Injury et Work? Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how Injury occurred Aftart nding Division 5 Pending Investigation 1 Naturel Injury To the Hospital or Attendition withing 24 hours and death.

To the Function ector: A completely uned in by the fo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 1.5. 24, 1998 2401 W Belvedere Ave 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) MD Hospital of Battimore Baltimore, NO 21215 sinai 32. Registrer's Signature State Julia Davidson Randall JUL 281998 Registrar

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DHMH 16 Rev 6/95

CALLS-SPE GIVE THE TOP BUT TO LATER AND A SECOND CONTRACTOR OF THE PROPERTY OF RESIDENCE.

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 09:46PM IRGINIA 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, giva street and number) BALTIMORE TOWSON GILLCREST HOSPICE CENTER If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex Months Deys 10 M 200 F Yrs 220-05-1303 MARYLAND November 6, 1913 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 210 No (FOVANS MD BALTIMORE 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street end Number 21739 REGESTER AVE 5. A 1113 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedant Ever in U,S. Armed Forcas? 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Navar Merried 2 ☐ Married 1 Yes 2 No Specify: whiTE Specify: 3 ₩idowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 th AJOYO-HIGH School 2 YEARS ACCOUNTANT 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maidan Sumame) BESSIE BURLIN ERNEST JOHANNESEN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N.J. 07836 VICKERY ETHEL MILDRED. TR. FLANDERS 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State owson, MD. Cem. 7/25/98 DULANEY Valley 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Facility Miller Funeral Home 21. Signature-of Funeral Service Licensee Nulls Ital Ford BOLTO, MO 21234 RD 7527 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel Colon cancer diseese or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 No 3 Probabiy 4 Unknown 24b. Were eutopsy findings eveilable prior to complation of causa of deeth? 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hogo Ce 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred 28b. Time of

Division of Vital Records, P.O. Box 68760 signed by the TONES VIRGINIA this certificate has ral director, page 2 Hospital or Attending Physician: 24 hours after death. Affier à

Physician/Medicai Examiner þ Completed Be P Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of health and Mental hygiene. Important: If item 27 is marked other than "natural". or the remaint average any injury or other traumatic averages.

Physician /Medical

Examiner

25. Was cese referred to medical 1 Yes 2 No 27, Manner of Death Naturel

2 Accident 3 Suicide

4 Homicide

5 Pending Investigation 6 Could not be determined

28e. Dete of Injury (Month, Day Year)

Injury

6701

28c. Injury et Work?

1 Yes 2 No 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N. Charles St. Balto. Md 2120x

Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29e. Certifier 29b. Signature and fittle of ce

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no

29c. License number

29d. Date signed (Month, Day, Year)

U State

Registrar

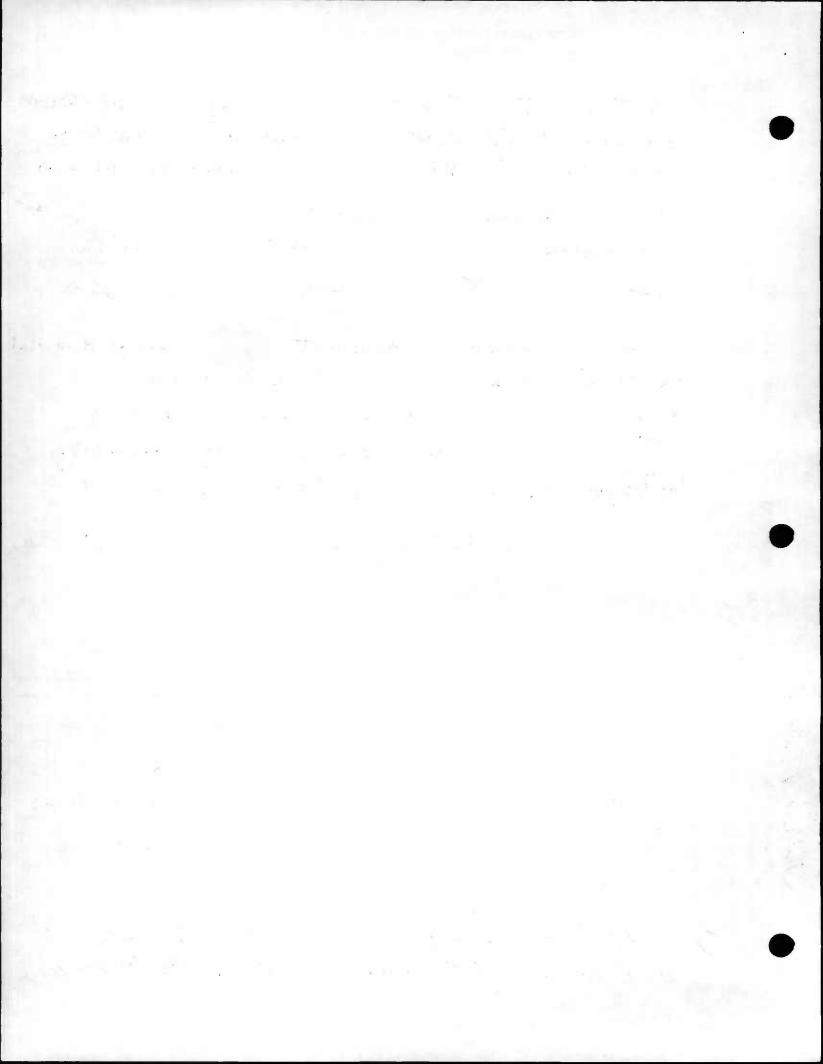
31. Data filed (Month, Day, Year) JUL 27 1998

32 Registrer's Signature Davidson

who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

To the Hospital of within 24 hours a To the Funeral D



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician Month Gordon J. Kram July 25 1998 1:18 am /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 8107 Pinecrest Avenue Rosedale Baltimore 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 11/10/1935 Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Deys 62 Yrs. 216-34-5383 Maryland Director Usuel Residence of Decedent with the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 sho other trsumstic event, It's Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Rosedale 10e. Street end Number 10g. Citizan of What Country? 10f. Zip Code 8107 Pinecrest Avenue United States 21237 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ♥ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Meritel Stetus Bleck, White, etc. filed within 72 hours efter 1 Never Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other treumatic event, the Median once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Food Products 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Be George Kram Naomi Arthur 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mrs. Joann Kram / Wife 8107 Pinecrest Avenue Baltimore. Md. 21237 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ■ Buriai 2 Cramation 3 Removel from State 7/27/98 Parkwood Cemetery Baltimore. Maryland 4 Donetion 5 Other (Specify) 21. Signature of Funaral Service Licensea 22. Nama and Addrass of Facility Schimunek Funeral Home, Inc. 9705 Belair Road Baltimore, Mado 9705 Belair Road Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** SMALL CELL CARCINOMA OF LUNG Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last Due to (or as e consequence of): physicial Division of Vital Records, P.O. Box 68760 Physician/Medical the the Due to (or es e consequence of): the ettending p 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2□ No 3 Probably 4 Unknown þ 2 24b. Were eutopsy findings eveileble prior to complation of causa of deeth? 24e. Was en eutopsy performed? Completed certificate hes 1 Yes 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA nours after death.

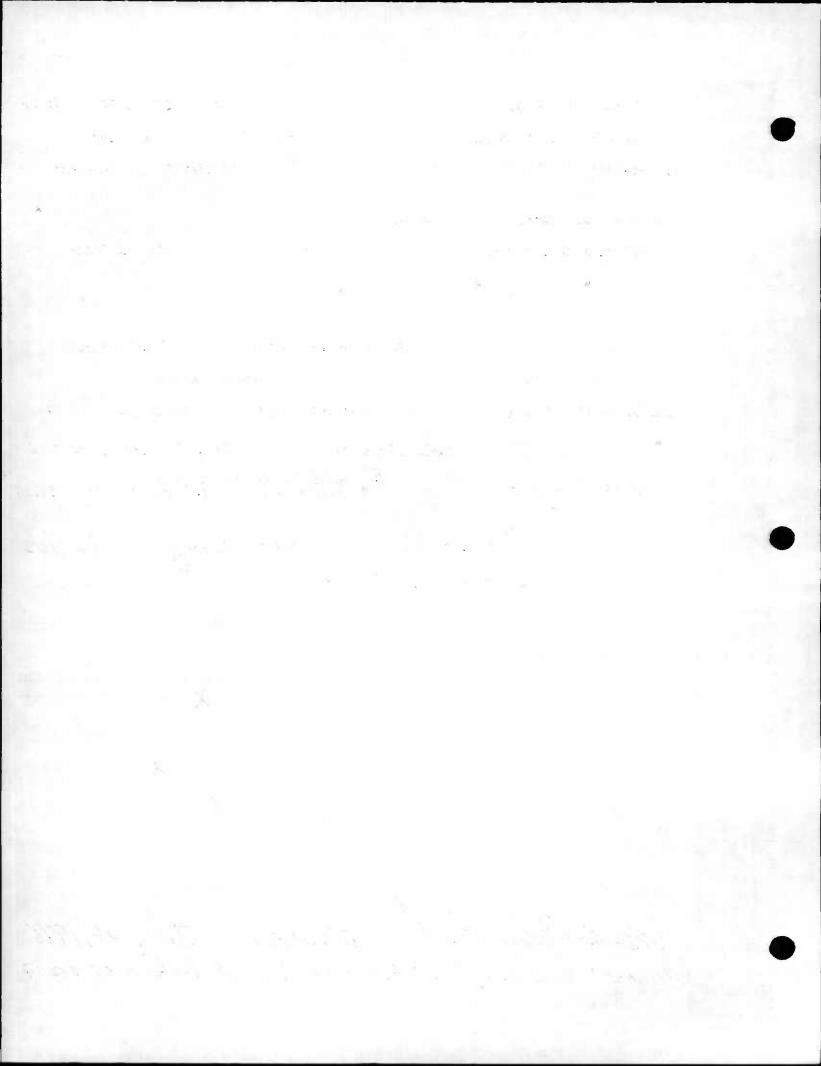
neral Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 6 To the Hospital o within 24 hours af To the Funeral DI completely filled is 16 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, daath occurred et the time, date end piece, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. Licensa number 29d. Data signad (Month, Dey, Year) 29b. Signeture end title of cestifie

ANKLIN SQ

State Registrar 30. Neme end eddrass of person who completed cause of deeth (Item 23a) (Type, Print)

32. Flegistrer's Signatura

wa Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** KORTN BENJAMIN NATHAN 63 23 /Medical 4b. City, Town, or Location of Beeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner GILCHRIST CENTER BALTIMORE TOWSON 6. Sex 1 M 2 □ F If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Yrs Director 216-32-8343 JAN. 26, 1906 MD Usual Rasidence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show arked other than "natural", or items 23e or 28e-f sho atic event, the Medical Examinar must be notified at 1 ☐ Yes 3 No Director MD BALTIMORE RANDALLSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21133 3801 SCHNAPER DRIVE #426 items 23a Funeral 12. Wes Dacedant Ever in U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14 Paca - American Indian Bleck, White, atc 1 Yes 2 No If Yas, Give X Yeer or Detes: 1 Naver Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grede completed) Hygiene. Elamantary/Sacondary (0-12) Collaga (1-4or 5+) PROPRIETOR SHOE STORE 18. Mother's Name (First, Middla, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental marked **ISAAC** KOBIN MOLLIE POLAKOFF 2 19a. Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) ANNE KOBIN (WIFE) 3801 SCHNAPER DRIVE #426 RANDALLSTOWN, MD 21133 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stete MOSES MONTIFICRE WOODMOOR 7/24/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligure 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onset end Deeth **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Str 1 week Examiner Dua to (or es e consequence of) Examiner physician end s the burial-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cousa (Disaasa or Injury that leited aspects.) Due to (or es a consequança of): Physician/Medicai that Initiated events Due to (or es e consequence of) resulting in deeth) Last USB 85 0 ed by the e Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2/2 No P 24b. Wera autopsy findings eveileble prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed peen page 2 s hes No 1 ☐ Yes 1∏Yes 2∏No this certificate director. Be 25. Was case referred to medical 26. Place of Deeth (Check only ona) Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) #2307 Cc 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Streat end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida

certificate be executed P.O. Box 68760, Records, Division of Vital

BENGAMIN N KOBIN

Hospital or Attending Physician: s efter death. tilled in by To the Funeral To the

> State Registrar

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29a. Certifier

29b. Signature and fitte of a

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1 Certifying Physicien: To the best of my knowledge, death occurred at tha time, date and place, and dua to tha ceuse(s) end mennar as statad.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end menner steted. 29c. License number

29d. Date signed (Month, Dey, Year)

Charles St. Balts. md 21204 ath (Item 23e) (Type, Print) 6701 Registrar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 27,28a-f,29c per M.D G-761 7/28/98 reb Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month Day Yaar CATHELINE **Physician** 5 650 AN 98 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ollace HUNGOMEN

Funeral Director

with the Marylend Directo "netural", or items 23a or olical Examiner must be death Funeral by Completed

Be

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Peges 1 and 2 should be filed within 72 hours effer nent of Health end Mentel Hygiene.
int: If Item 27 is marked other than "natural", or its Baltimore, Depertment of H ò

> Physician /Medical Examiner

> > physiclen s the buria attending p for use es been signed by the should be deteched il director, pege 2 s this

certificate be executed Records, Division of Vital Attanding Physician: efter death. Director: Aft A 24 hou. the Funeral Disò Hospital To the Fune completely f To the To the To the F

Examiner Physician/Medical þ Completed Be Certification: Medicai

1 Navar Marriad 2 Married 3 ☐ Widowed 4 ☐ Divorced Elementary/Secondary (0-12) 17. Father's Neme (First, Middla, Last) 20a. Mathod of Disposition 4 Donation 5 ☐ Other (Specify)

If Undar 1 Yaar if Under 24 Hrs. 9. Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 1□ M 25∤F 7. Aga (In yrs. last birthday) Yaar) Months Days Hours 89 Yrs March 9, 309-34-2469 1909 Kentucky Usuel Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 15311 Pine Orchard Drive 20906 U.S.A. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. Specify: White 1 ☐ Yas 2 ☑ No Specify: 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Collaga (1-4or 5+) unknown unknown 18. Mothar's Nama (First, Middla, Maidan Sumama) Hiram Franklin Shelman Anna Dutschke 9b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 15311 Pine Orchard Drive, Silver Spring, Maryland 15312 Pine Orchard Drive, Silver Spring, Maryland 19a. Informant's Name/Relationship (Type, Print) Wallace B. Knapp/husband 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 21. Signatura of Fu) aral Service Licenseas, Wade, Director 22 Name and Address of Facility Board, 655 W. Baltimore, Maryland 23e. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. Approximata Interval Batwean Onset and Daath Immediata Causa (Final disaasa or condition resulting in deeth) secondary to odonton Dua to (or as a consequence of)

Sequentially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last PEROSIS Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTA

24e. Wes an autopsy 1□ Yes

25. Was casa rafarrad to madicel axarmar? 1 Yas 2□ No 1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Deeth Date of injury (Menth, Day Year) XX Natural 5 Panding Investigation 3 Suicida

40 6 Could not be determined Placa of injury - At homa, farm, straat, factory, offica building, etc. (Specify)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28b. Tima of 28c. Injury at Work? 1 Yas -24 No

28d. Dascribe how Injury occurred

26. Placa of Daath (Chack only ona)

28f. Location (Straat and Number or Rural Routa Number, 5 City or Town, Stata) 02906 1🗹 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceuse(s) and mannar as statad.

2 19 No

aucalah aro

4 D Homicide

(Check only one)

29a. Cartifiar

29c. Licansa number D-33641

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Date signad (Month, Day, Year)

24b. Wara autopsy findings availabla prior to complation of causa of daath?

1 Tyas 2 THO

30. Nama and address of person who complated cause of deeth (Item 23e) (Type, Print)

Levin ME MAhow

Oland wood Cf 32. Registrars Signatura Raydass 31. Date filed (Month, Day, Year) JUL 281998

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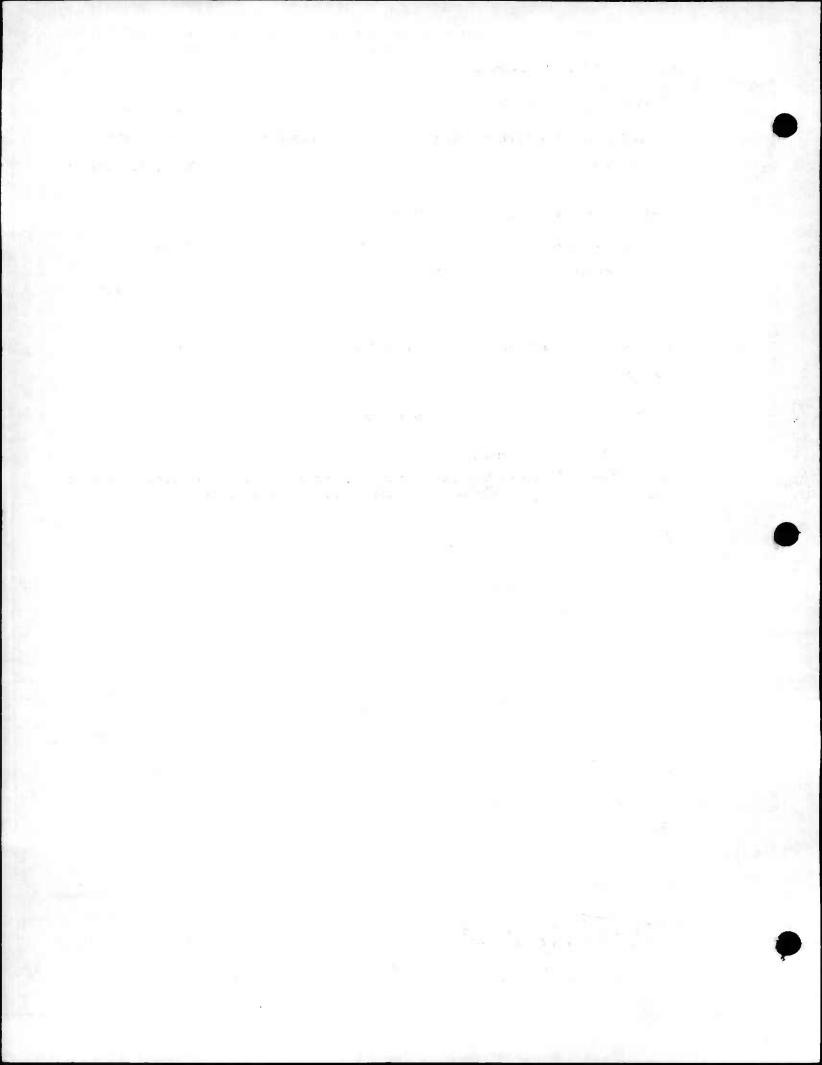
State of Maryland / Department of Health and Mental Hygiene

Item: 27 per M.D G-761 7/28/98 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** John Lucas July 1998 8:00 Am 18 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecilify Neme (If not institution, give street end number) **Examiner** Takoma Park Montgomery Washington Adventist Hospital If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey Year) 1935 Sirthplace (State or Foreign Country) unknown 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) **Funeral** Days Months 1₩ M 2□ F 187-28-2444 **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumetic event, the Medical Examinar must be notified at 1 ☐ Yas 3 ☐ No Director Maryland Prince Georges Hyattsville 10e. Street end Number 10f Zin Code 10g. Citizan of What Country? 6500 Riggs Road 20783 U.S.A. "natural", or items 23s. Funeral 11. Maritel Status unknown Wes Decedent Eyer in U.S. Armed Forces? UNKNOWN
 Wes Decedent of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black ğ 3 Widowad 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantary/Sacondery (0-12) College (1-4or 5+) unknown unknown unknown unknown permit. Pages 1 and 2 should be file.
Department of Health and Mantal My important: If them 27 is marked other any injury or other traumette. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be unknown unknown 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rural Route Number, City or Town, Stete, Zip Code) unknown unknown 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 € Other (Specify) in state 21. Signature of Fuperal Service Licens Ronald S 22. Name and Address of Fecility ad∉, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a Part 1. Enter the disaasa, or complications that caused the daeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one causa on each line. Approximete Intarval Batwaan Onset end Death Physician Immediete Ceuse (Final diseese or condition resulting In death) /Medicai Examiner Examiner CANCER certificate be executed buriel-transit ettending physician and for use es the buriel-trar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Dae to (or es e consequenca of) Box 68760. Physician/Medical that initieted events resulting in deeth) Lest Due to (or as e consequenca of) use es the P.O. | Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA Records. 8 24b. Wera eutopsy findings eveilable prior to completion of cause of daath? Completed 24a. Was an autopsy certificate hes 1 Yes 2 IN 1 ☐ Yes 2 ☐ No Kidde BEN Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, 25. Wes case rafarrad to medical exeminer? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No 27. Mannar of Death 28e. Deta of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Panding investigation XX Nature! 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcide 6 Could not be by 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledga, daath occurred at tha tima, date end pleca, end due to the cause(s) and manner as stated.

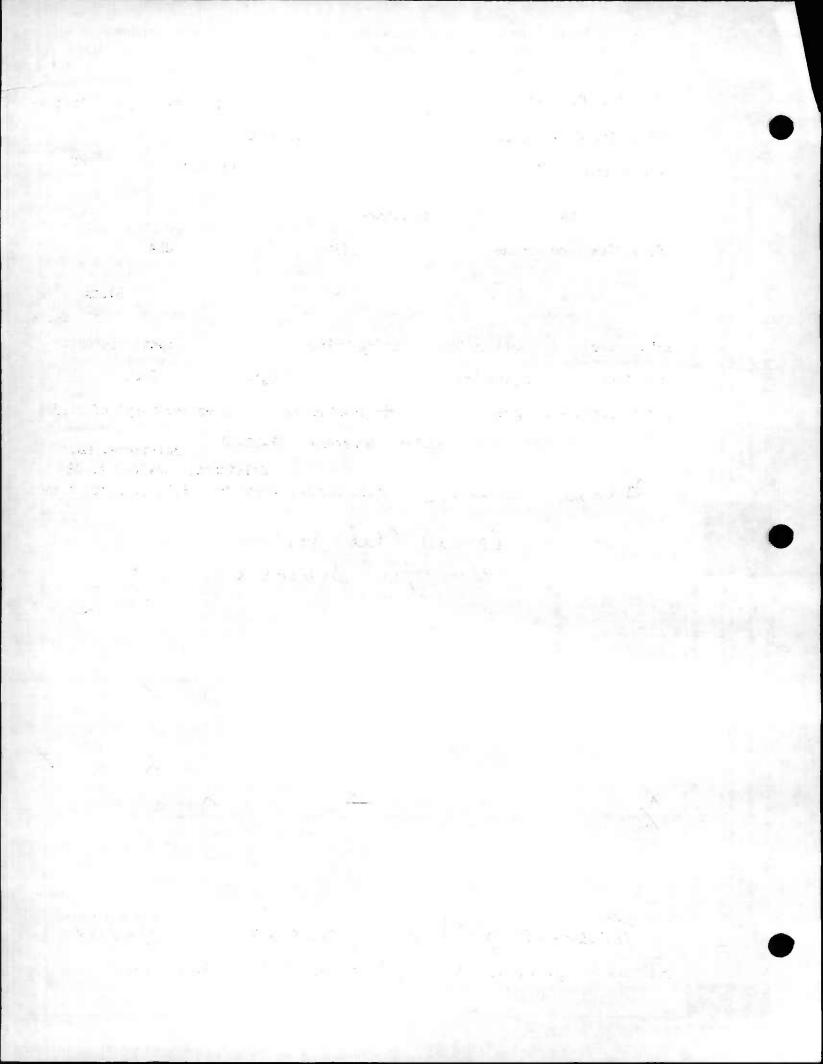
2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, data end placa, and dua to the causa(s) end menner stated. 29a. Certifier Medicai 29b. Signeture and title of certifier 29c. Licanse numbar 29d. Dete signed (Month, Dey, Yeer) 1052927 30. Neme end eddress of person who mplatad causa of deeth (Item 23a) (Typa, Print) 832 Muddy Rd GAITHERSburg, Md. 20878 mi THEODORO 31. Data filed (Month, Day, Year) 32. Hogistrar's Signatura State la Devidor-Rondelle 281998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. amend item 19b per informant G790 12/25/06 of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#26 per Phy G761 7/28/98 EW Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Day Month Year **Physician** Gilbert R. Logan 23. 98 July 10:16am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 4800 Yellow Wood Avenue Baltimore 7. Age (In yrs. last birthday) ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 10-02-36 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1X3 M 2□ F Director 212-34-6090 Usual Residence of Decedent death with the Maryland 10e. State 10d. Inside City Limits 10b. County 10c. City, Town or Location in than "naturel", or items 23e or 28e-f show on Medical Examiner must be notified at XX Yes 2□ No Director NA Baltimore 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 4800 Yellow Wood Avenue 21209 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after Department of Haaith and Mental Hygiena. Important: If item 27 is marked other than "naturel", or itel any injury or other traumatic event, the Wed cal Examina once. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry Admin. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College Grad 12th Grade Social Security Policy Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Cook Maggie Lawrence Logan, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5816 Trimbleway Logan - Daughter Rosedale, Maryland 21237 Linda 20b. Place of Disposition (Name of competery, crematory or other place WOOD Lawn Cemetery 20a. Method of Disposition

↑ □ Burial 2 □ Cremetion 3 □ Removal from State 20c. Location - City or Town, State 07-28-98 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee la WM.C. March Funeral Home 1101 E. North Avenue Warne 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) na Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificete be Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use ontributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate has I 1 Yes 2 No 2 1 No 1 ☐ Yes Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check anly one) Be Other: 4 Nursing Home 5 Apsidence 6 Other (Specify) 1 Ves 2 No Certification: To 1 Inpatient 2 ER/Outpatient this Aftar this funaral of er of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending daath. 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hour. the Funeral Directory filled in 1x Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune complately fi 29b. Signature and the of certifier 29c. License number 29d. Date sign/ed (Month, Day, Year) 2808 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 2411 W. Belveder in Stillow Margulies mo mo Se. 1 hours 28199832. Registrar's Gignature State Registrar



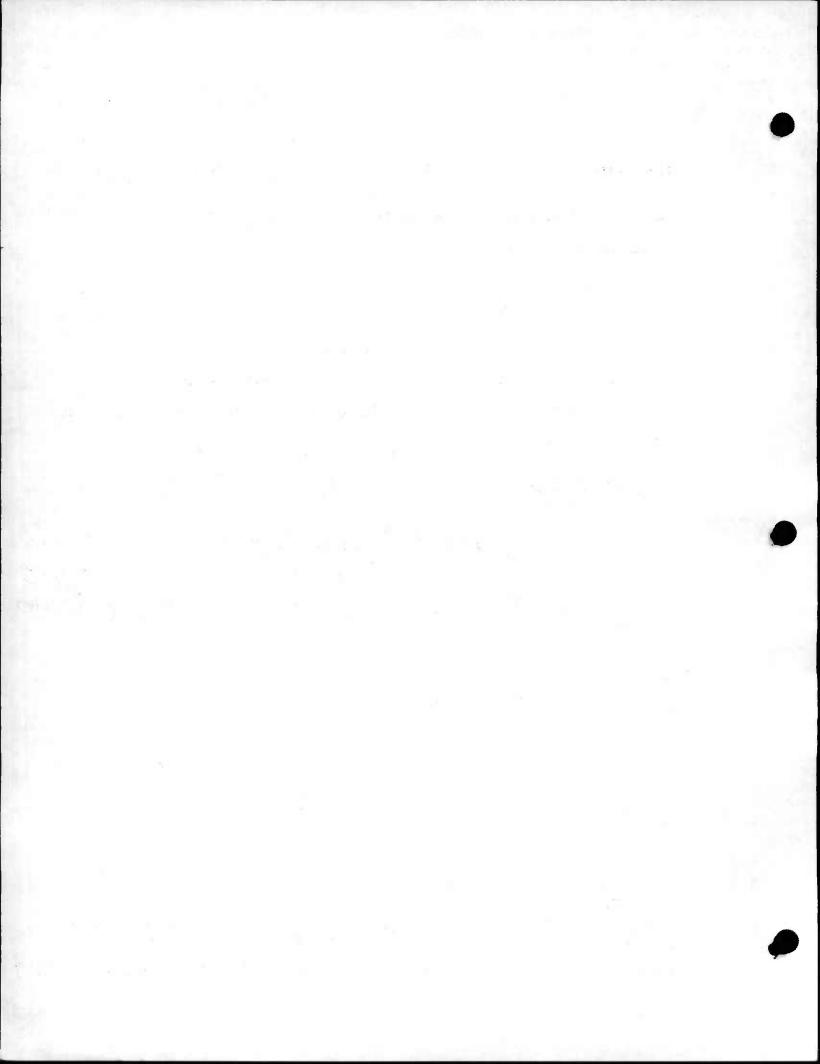
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Adam Richard Lazon 2. Dete of Deeth 3. Time of Deeth July July **Physician** 2:25 pm /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Stella Maris Baltimore Towson If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Yeer Birthplece (State or Foreign Country) **Funeral** 18 M 2□ F Months Deys Director 190-09-0397 2/19/1907 Pennsylvania Usuel Residence of Decedent 10e. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Med cal Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Pa. Westmoreland Pittsburgh 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1523 Berkshire Drive 15226 items 23a United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) e filed within 72 hours after all Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 2 No Specify. þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondery (0-12) College (1-4or 5+) 12 Installer Utility permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is merked other only injury or other treumetic event once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be Adam S. Lazon Anna Sakko 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty Ann Hirst / Daughter 915 Clifton Road Bethel Park. Pa. 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca, 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Queen of Heaven Cem. 7/29/98 Peters Twp., Pa. 22. Name end Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mare 9705 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the diseese, or complications shock, or heert faiture. List only one ications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, ne cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner ettending physician end for use es the burak-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Box 68760, thet initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 2 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy page 2 s certificate has 1 Yes 2 No of Vital or Attending Physician: director, 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Yes > No Other: Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA After this within 24 hours after deeth.

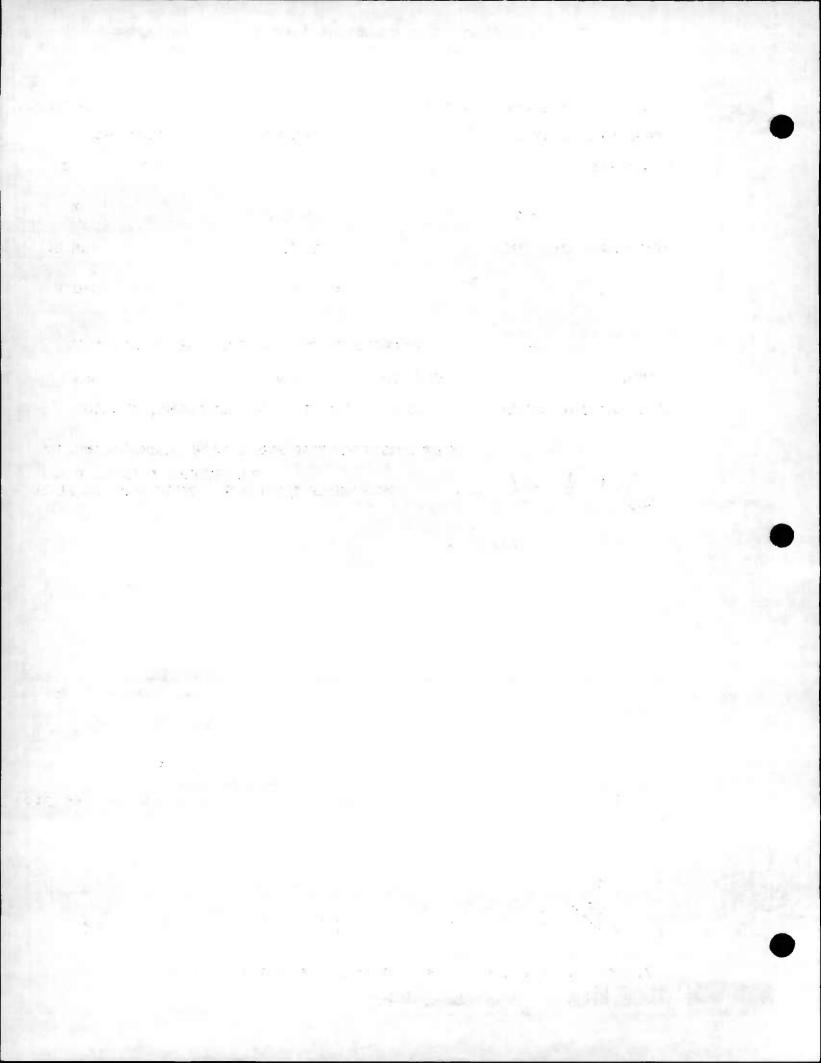
To the Funeral Director: After thi
completely filled in by the funerel 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deet 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Division Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medicai 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the bests of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner, stated. To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dey, Yeer) 30 Name end eddress of person white comple R. SUITE 302 31. Dete filed (Month, Day, Year) 32/ Registrer's Signature State 281998 Julia Davidson Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Year **Physician** 22, 1998 WEISSMAN July 10:50 a.m SYLVIA LURTE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE STELLA MARIS HOSPICE TTMONTUM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yee MAY 20, 1 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 20XF Hours Yrs. 88 1910 CT **Director** 216-28-5742 Usual Residence of Decedent with the Marylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f sho traumetic event, the Madical Examinar must be notified at 1 X Yes 2 □ No Directo N/A BALTIMORE 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 3737 CLARKS LANE #304 21215 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ PSYCHIATRIC SOCIAL WORKER STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h end Mental h Pages 1 and 2 should be **JOSEPH** WEISSMAN FANNIE BLUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Heelth er Important: if item 27 is any injury or other trau 9236 JAMES HOWARD LANE JUDIE LURIE (DAUGHTER) BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL PARK 7/24/98 REISTERSTOWN, MD 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 ura Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Lung Cancer **Examiner** Due to (or as a consequence of): Examiner death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last bunel-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medicai the Due to (or as a consequence of): as ed by the ettending | for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown þ 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed page 2 s hes 2X No 1 Yes 1 ☐ Yes 2 ☐ No certificate ision of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Kether (Specify) Hospice 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No death. M 2 Accident ster death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined within 24 hours after de To the Funeral Direct 3 ☐ Sulcide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edicai 29a. Certifie 1 🔯 Cardilying physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner es steted. Iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29c. Liceqse number 29b. Signature end III . 22 - 98 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year JULY 23, 1998 8:05 AM PAULTNE LEVINE 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2 HIGHSTEPPER COURT #504 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 M XXF Yrs. 213-26-7800 69 JAN.8, 1929 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE MD BALTIMORE 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number 2 HIGHSTEPPER COURT #504 21208 U.S.A. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or NoIf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK MEDICAL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) REUBEN **LENENBERG** ANNETTE ETSENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL FRIEDLER (DAUGHTER) 1606 NEAR THICKET LANE STEVENSON, MD 21153 20a. Method of Disposition 14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 7/26/98 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Death CANCER Immediate Ceuse (Finel disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy

completion of cause of death?

1 Yes 2 No

1 🗌 Yes

28d. Describe how injury occurred

26. Place of Death (Check only one)

28c. Injury at Work?

Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Qate signed (Month, Day, Year)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be

2

Examiner

Be

Medical

25. Was cese referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

1 ☐ Yes

27. Manner of Deeth

Natural Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

Funeral

Director

r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at

with the Maryland

Pages 1 and 2 should be filed within 72 hours aftar death vinant of Health and Mental Hyglana.

is marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event area.

altimore, Maryland 21215-0020

attending physician and for use as the bunal-transit ed by the detached signed l been si

The law requires that the death certificate be executed certificate has b lirector, page 2 s or Attanding Physicien: director, this After this death.

Division of Vital Records, P.O. Box 68760 Physician/Medical à Completed Certification: To

To the Hospital or Attandir within 24 hours after death.
To the Funeral Director: Al

State Registra

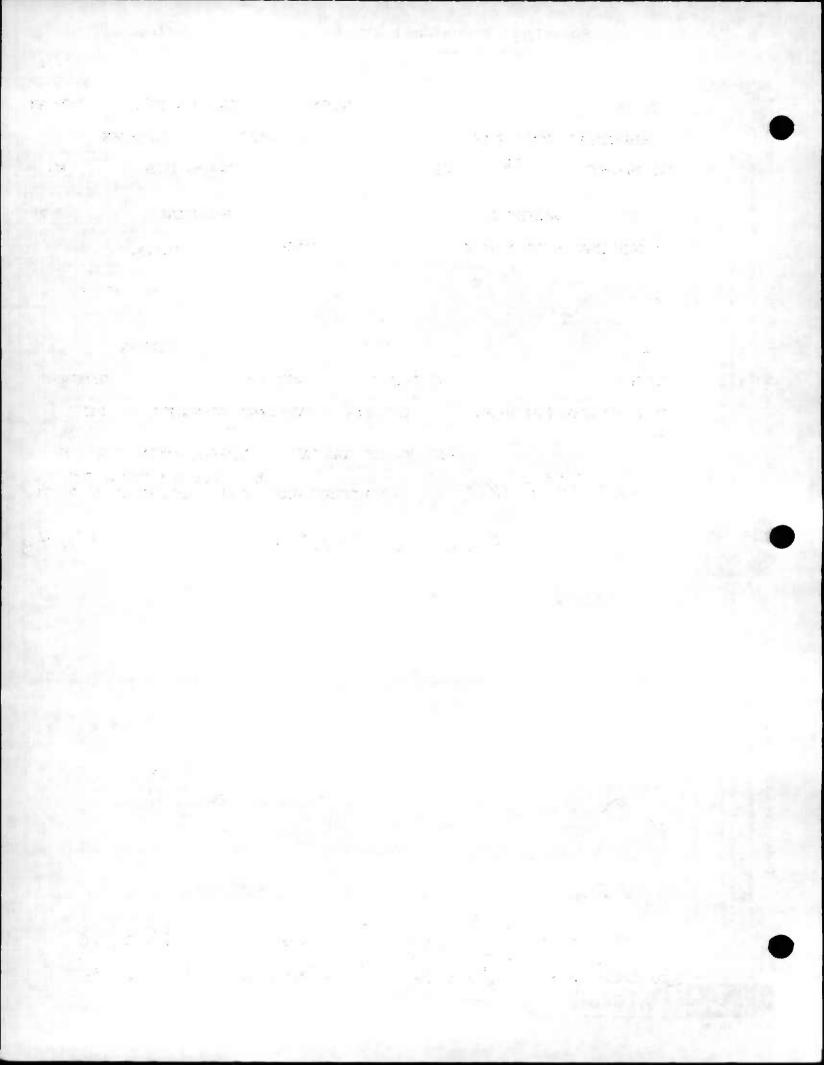
of teath (Item 23a) (Type, Print) 30. Name and address of person who complete Driver DICrossoads

1 inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28e. Dete of Injury (Month, Day Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Month **Physician** 27 1998 July 12:30 am Edward Sprogal Lee, Jr. ' /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Undar 24 Hrs. If Undar 1 Year 8. Data of Birth (Month, Day, Yaar) June 5,1923 9. Birthplaca (Stata or Foraign Country) Pennsylvania 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Yrs. Director 141-16-3073 75 Usual Rasidanca of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Insida City Limits 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Health and Mental Hygiene. Imprortant: If item 27 Is marked other than "natural; or items 23a or 28a-f show any plury or other traumatic event, its Medical Exprimer, mail or notified as 1 ☐ Yas 2 No Arme Arundel Edgewater MD Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21037-2718 USA 105 Welchs Drive Funeral 12. Wes Decedent Evar In U,S. Armad Forces? 1 X Yas 2 □ No if Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 □ Navar Married 2 N Married White 1 Yes 20XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Upholsterer Automotive 12 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be Ethel Ruth Stinger Edward Sprogal Lee, Sr. 2 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) 105 Welchs Drive, Edgewater, MD 21037-2718 Ella Katherine Murphy 20b. Place of Disposition (Name of camatary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Removal from Stata 30 4 ☐ Donetion 5 ☐ Othar (Spacify) Fort Lincoln Cemetery Brentwood, Maryland 22. Nema end Address of Facility 21. Signature of Funeral Service Licenses Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1/ Enter tha diseasa, or complications that shock, or heart failure. List only one couse on antar tha moda of dying, such es cardiac or respiratory arrast, Approximata Interval Batween Onset and Deeth **Physician** Immedieta Ceuse (Final diseasa or condition rasulting in daath) /Medical Examiner Dua to (dr.as a consequence of): Physician/Medical Examiner recommonia Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of) signed by the attending physician Id be deteched for use as the burial that initiated events resulting in death) Last Due to (or es a consequance of) W513 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No à 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy parformed? Completed peen certificate has 1 🗆 Yas 2 No 1 ☐ Yas 2 No director, Be 25. Was casa rafarrad to madicel examinar? 26. Placa of Deeth (Check only ona) Hospital: Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas No P 15 Inpatiant 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28d. Dascriba how injury occurred Certification: 28b. Tima of 28c. Injury at Work? Attending 5 Pending invastigation 1 Natural 2 Accidant deeth. 1 Yes 2 No Hospital or Attendi 24 hours after deeth Funeral Director: 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifian

29c. Licansa number

MI

a Laurdson Amore

eted cause of death (Itam 23a) (Type, Print)

3 Registrar's Signature

29d. Data signed (Month. Day, Year)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records.

Division of Vital

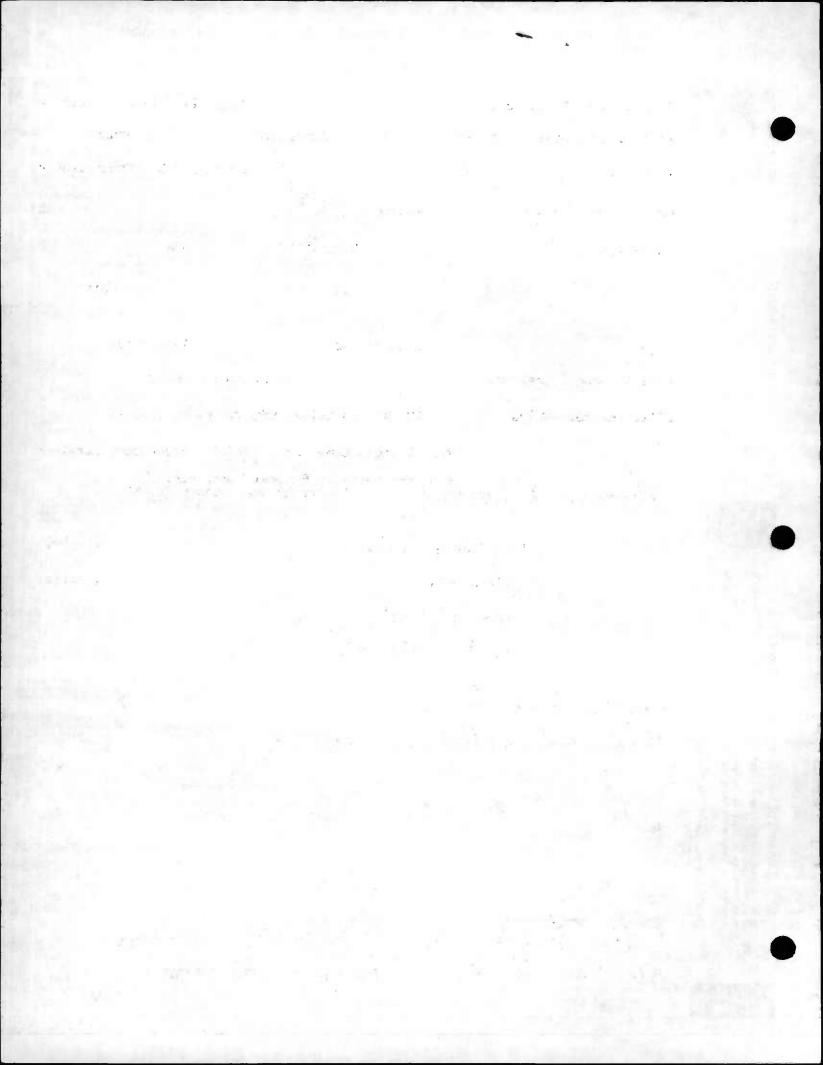
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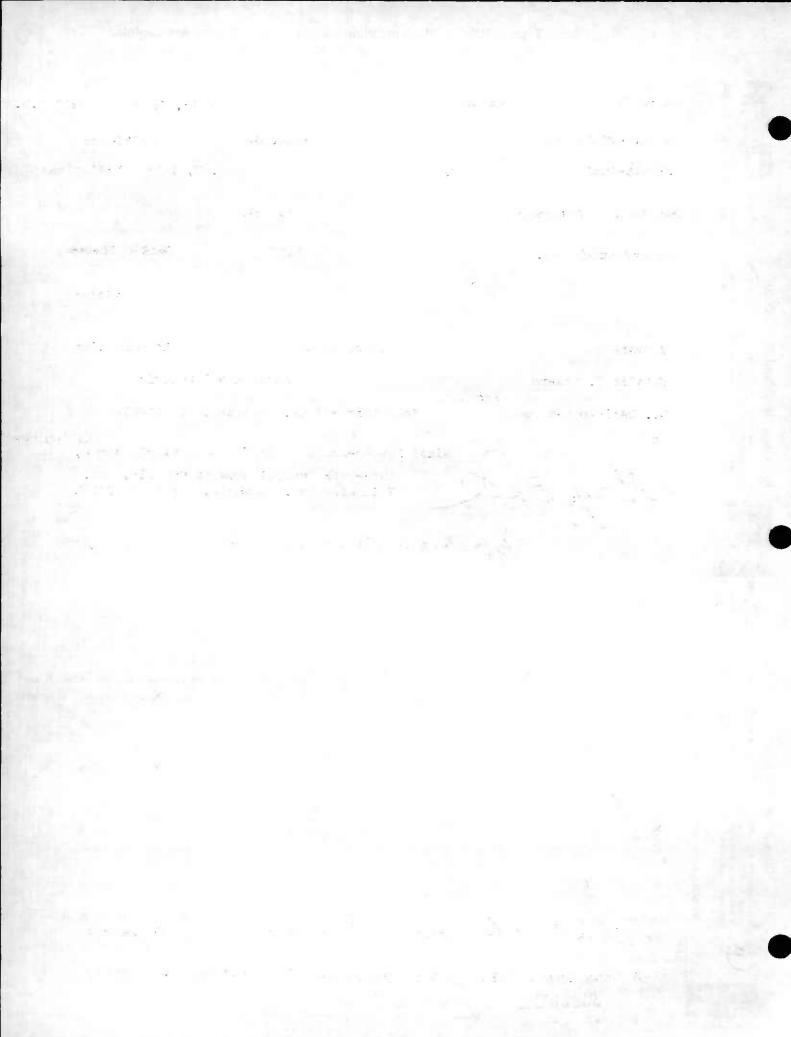
30. Nama and address of person who com

29b. Signatura a

12 31. Data filad (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician** Ambrocia Lazaro July 23, 1998 9:11 P.M. /Medical 4e Fecllity Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 40 Cartwright Court Rosedale Baltimore If Under 1 Year If Under 24 Hrs. Hours | Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□ M 21XF Yes Director 218-19-6031 Philippines 82 Dec. 7, 1915 Usual Residence of Decedent the Maryland 10d. Inside City Limits stal Hygiene. actural, or itema 23a or 28a-i show of other than "natural", or itema 23a or 28a-i show event, the Medical Enaminer must be notified at 10e. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Rosedale Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with Philippines 40 Cartwright Ct. 21237 death 1 Funeral 14. Reca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Menitel Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Rem 27 is merked other than "natural", or iten and jujury or other traumetic event, the interest", or iten 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Filipino by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7 Years Housekeeper Housekeeping 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Agustina del Rosario Natalio G. Lazaro 19a. Informent's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6463 Mainsail Ct. Orlando, FL 32807 Dr. Benigno Lazaro 20b. Pleca of Disposition (Neme of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Philippines 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/4/1998 Rizal Neueba, Rizal Neueba-Ecsia 21. Signature of Faheral Service Licensee 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. Dumdalk, Maryland 7922 Wise Ave. Do not enter the mode of dying, such es cardiec or respiretory errest, loations that caused the done cause on each line. Approximete Intervel Between Onset end Death **Physician** Condovesala disen Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner the burney Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760 The law requires that the death certificate Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been sig Completed 24a. Wes en eutopsy performed? this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral c 28c. Injury et Work? 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homleide hin 24 hours af the Funeral Di mpletely filled in Hospital 1 dertifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end manner stated. 29a. Certifier Medicai To the To the Comple 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier MD 0-18151 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Chi-Shiang Chen, M.D. #410 Balto., MD 98 N. Broadway wha Davidson 31. Date filed (Month, Flav Year) 8 1998 32. Registr State Randell Registrar **DHMH 16 Ray 6/95**



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

				te of Death	Re	g. No. 3 0	23077					
Physician /Medical	1. Decedent's Name (First, Middle, Last, MARGARET	ANN LO	OGUE	1 0 T	IV	Dey 24 19	Yaar 3. Time of Death					
Examiner Funeral Director	213-68-0612	Towson	Months	4b. City, Town, or L		Year)	of Deeth LTIMORB 9. Birthplece (State or Foreign Country) Md.					
the Maryland 28s-f show notified at	Usuel Residence of Decedent 10a. Stete 10b. County		10d. Inside City Limits 1 ☐ Yes 2 ☑ No									
iter death with the Mar r thems 23e or 28e-1 si instring De notified Funeral Director	Md BSLTIMORE BALTIMORE Md. 100. Street and Number 100. Street and Number 100. Street and Number 100. Citizen of When the Street and Number 100. Citizen of When the Street and Number 100. Street and Number 100. Street and Number											
by	11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forcas? 1 Yes 2 M No If Yes, Giva Year or Detes:	S. 13. Was Deci if Yes, sp	edant of Hispenic Origin? (S ecity Cuban, Mexican, Puert 2 No Specity:	pecify Yes or No- b Rican, etc.)	14. Race Bleck	a - American Indian, k, White, etc.					
within 72 ene. then "nat he Medic	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		nei Occupation ork dona during most of wor usa retired) EMAKER	king	16b. Kind of Business/Industry						
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or other	7HOMAS LOGUE 20a. Method of Disposition 18 Buriel 2 Cremetion 3 F	C	Place of Disposition (Ne emetery, cremetory or	other pieca)	Dete	20c. Location -	City or Town, State					
permit. Per Depertment Important: any Injury once.	21. Signeture of Funeral Service Licensea WEW CATheolese Cem. 728 BALTMORE Md. 22. Name and Address of Eacility //ER FUNERAL HOME, CH7D. 7527 HARFORD Rd. BALTO Md 21234											
Physician /Medical Examiner	23a. Part1. Enfer the disease, or somple shock, or haart failura. List only or limmediata Cause (Finel disease or condition resulting in death)	Pul mo,	h. Do not enter the mo	Bolism	or respiretory erre	est,	Approximete Intervel Between Onset end Deeth					
e attending physician add to use as the burial-transit is iclan/Medical Examiner	that initieted events resulting in daeth) Last		r as e consequenca of	77.1			2 40865					
	Pert ii. Other significant conditions con		ulting in the underlying	cause given in Pert I.	23b. Did to	V	ntribute to the cause of death?					
been signe should be d	ostogo	20503			24e. Was e	n autopsy	24b. Were autopsy findings eveileble prior to completion of cause of death?					
certificata has rector, page 2					1 □ Yε		1 ☐ Yes 2 ☐ No					
h. After this funeral di	25. Was case referred to medical exeminer? 1 Yes 2 O 27. Manner of Daeth 1 Naturel 5 Panding 2 Accident invastigation	Hospital: 1 inpatient 2 2 28a. Dete of injury (Month, Dey Year)	ER/Outpetient 3 C 28b. Time of Injury	Others	eath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
To the Hospital or Attending P within 24 hours after death to the Funeral Director. After completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	98 One Disco of Lives A home form street feeters office. 28t Location (Street and Number or Rural Route And										
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examine end menner stated.	tion end/or Investigation	n, in my opinion, daath occu	rred et the time, de	ate end placa, e	end due to the ceuse(s)					
Within Com	29b. Signature and title of cartifier	Rdula	r mb.	D 27394	2	9d. Date signed	1 (Month, Dey, Year)					
P	30. Name and address of person who co	hardson mo J	7601 Lich	Raves BLUD	#203	BALTS.	mo 21239					
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Signe	Andelle									

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0200Hes M. Bernadette Malarkey JULY 17 1998 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 7, 1915 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) 5. Social Security Number Yrs. 208 40 5226 Pennsylvania Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland **Baltimore** Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 4100 Maple Avenue 21227 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Baca - American Indien. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 Yes 2 XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Religious 4 years 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James P. Malarkey Lydia (not available) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Sr. M. Pauline Bibrough 4100 Maple Avenue Baltimore, Maryland 21227 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 7/21/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 10ncl 23a. Part1. Enter the disease shock, or heart talking. o, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Interval Between Onset and Deeth ACUTE PULMONARY EDEMA Immediate Ceuse (Final 24 HRS. disease or condition resulting in death) Due to (or es a consequence of): CONGESTIVE HEART FAILURE 72 HRS LONG STANDING Due to (or as e consequence of) LONG STANDING Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown 24e. Wes en eutopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

2

Funeral

Director

item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumate.

Maryland 21215-0020

altimore,

MALARKE

RE ENABETTE

Division of Vital Records, P.O. Box 68760,

with the Maryland

death v

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

URDSEPSIS

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical 89 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Dete of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 Yes 2 No

27. Manner of Deeth 1 Naturel 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner steted.

29b. Signature and IIII

29c. License number MEDICAL RESUENT

29d. Date signed (Month, Day, Year)

Completed

2

Certification:

edical

page 2

certificate

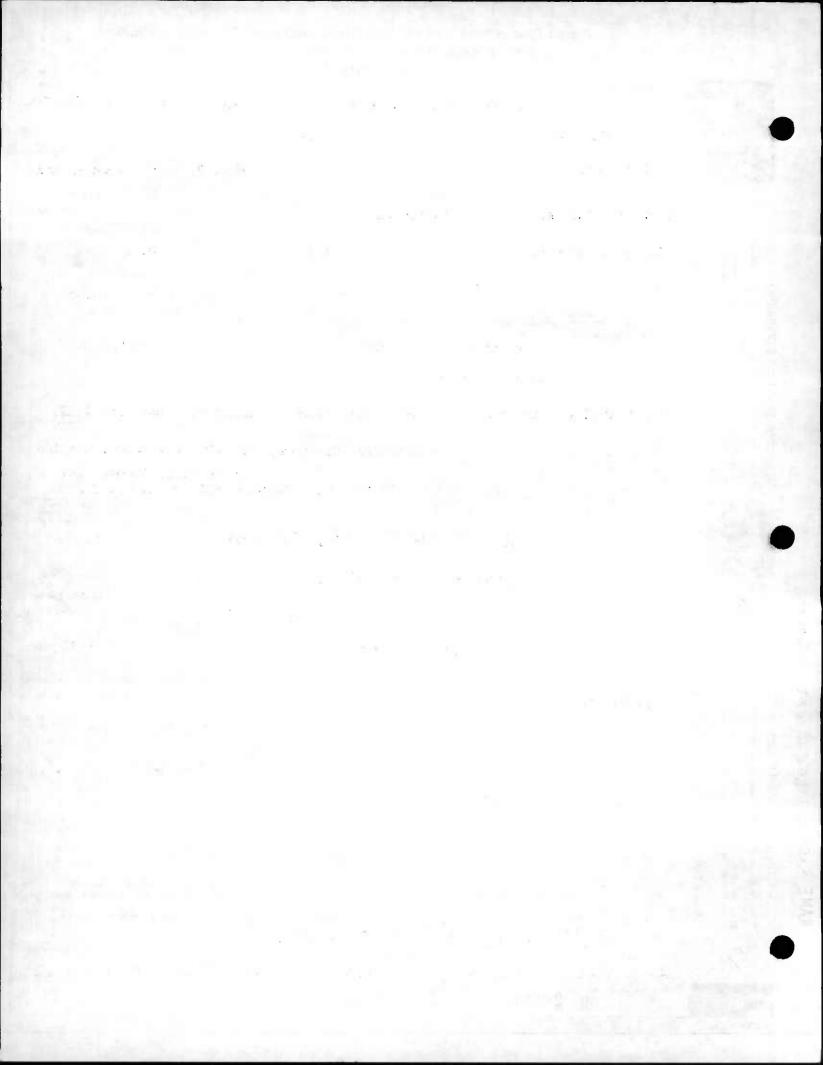
\$

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) CHARLES MBONU

900 CATON AVENUE BALTIMORE MD 21229

State Registrar

Within 2 To the



Plea	ise Type or Pi	rint in f	Biack ir	ndeiible	e ink.	Assı	ıre A	il Copies	s Are	e Legi	ble.			
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4e Fecility Neme (If not institution						b. City, To	wn, or Lo	ocation of Deel	th 4	c. County	of Death			
The Memoria	1 Hospita	1				Eas	ston	1		Talk	oot			
5. Social Security Number	6. Sex 7.		lest birthday		r 1 Year	If Under	24 Hrs.	8. Date of Bi	irth Von	-1	9. Birthr	plece (State or Foreign		
213-64-8589 HNK	1₩ 2□ F	45	5 Yrs.	Months	Days	Hours	Min.	(Month, D AUG.		1952	Man	ryland		
Usual Residence of Decedent								I AUG.	1,	1774	Liai	Lylanu		
10a. State 10b. County		10c. Cit	ty, Town or L	ocation							1	10d. Inside City Limits		
Maryland D	orchester				Car	hair	1 ~ c					1 ☐ Yes 2√2 No		
10e. Street end Number	OLCHESCEL			10f. Zip		brid	Ige		10g. C	Citizen of 1	Whet Cour	ntrv?		
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11. Maritei Status	12. Was Decede Armed Force	eş?	,S. 13.	If Yes, spe	cify Cube	ispanic On in, Mexica	n, Puerto	pecify Yes or N o Rican, etc.)	10-		ck, White,			
1 Never Merried 2 Mari	It Yes, Give			1□Yes	2 ∑ No	Specify:	:			Specif	y: Wł	White		
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Elementery/Secondary (0-12)	College (1-4d	or 5+)		rpent					Mi	9001	Tanc	eous Jobs		
17. Fether's Neme (First, Middle,	Last)		00.	LPCII				ne (First, Middle	e, Meide	en Sumer	ne)	10us_Jous		
	d Mickola	jczyk	7			Ar	ına	Cioto	la					
19e. Informent's Name/Reletions	ship (Type, Print)		19b. Mai	ling Address	s (Street	and Numb	er or Rui	rel Route Numi	ber, City	y or Town	Stete, Zir.	Code)		
Richard Mickola;	iczyk/fathe	r	981	9 Ric	h 1 w	n Dr	- 1 170	Peri	₩ 3 7	U . 1 1	МТ	21120		
20e. Method of Disposition 1 Burial 2 Cremetion 4 Donetion 5 Other (S	3 ☐Removel from Sta	20b. F	Piece of Disp cemetery, cre tro Cr	position (Ner emetory or o	me of other plec	ce)		Date 7/27/98	20c.	Location -		own, State		
21. Signature Funeral Service		1100		22. Name an	4./			121190		вать	lmor	ce, MD		
23a. Pert1. Enter the disease, or	McDonal recomplications that cause	Madd deal sed the deal		Crema 299 F	red	n So eric	cie k R		Bal	ryla timo		MD 21228 Approximete		
shock, or heart failure. List	only one ceuse on each	n line.									1	fritervel Between Onset end Deeth		
Immediate Ceuse (Finel disease or condition resulting in deeth)	. Hype							-				Hours		
		Due to (c	or es e conse	aquence of):	,						1			
	_ h Rena	1 Fai	ilure								I	Days		
Sequentially list conditions,	0.	Due to (or es e consequence of):								1				
if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Mult	iple	Syst	em O	cgan	Fai	llur	re			†	Dave		
that initiated events	C		or es e conse								1	Days		
resulting in death) Lest											+			
	d Seps	15									<u> </u>			
Part II. Other significent condition	ons contributing to deal	h but not res	sulting in the	underlying c	cause giv	en in Pert	I.	23b. Dfc	d tobac	co use co	ntribute t	to the cause of death?		
Alcoholic								10] Yes	2)X(No	3 □ Pro	obably 4 Unknow		

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.

Within 24 hours after death.

To the 24 hours after death.

Completely filled Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be deteched for use as the burner.

Physician/Medical Examiner

Medical Certification: To Be Completed by

Item#5 perFl

Physician /Medical

Examiner

Funeral Director

Rich 20e. Me

To Be Completed by Funeral Director

Sequentif eny, le cause.
Ceuse (that initiresulting

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an eutopsy periormed? 2 No 2 No 1 Yes 1 Tyes

25. Wes case referrexaminer?	ed to medical
1 ☐ Yes 2	No
27. Manner of Death	
1 Neturel	5 Pending
2 Accident	Investigation

1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury et Work? М 1 Yes 2 🔲 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

	28d. Describe how injury occurred
No	
	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

6 Couid not be determined 3 Sulcide 4 I Homicide

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s)

29b. Signature and (i)

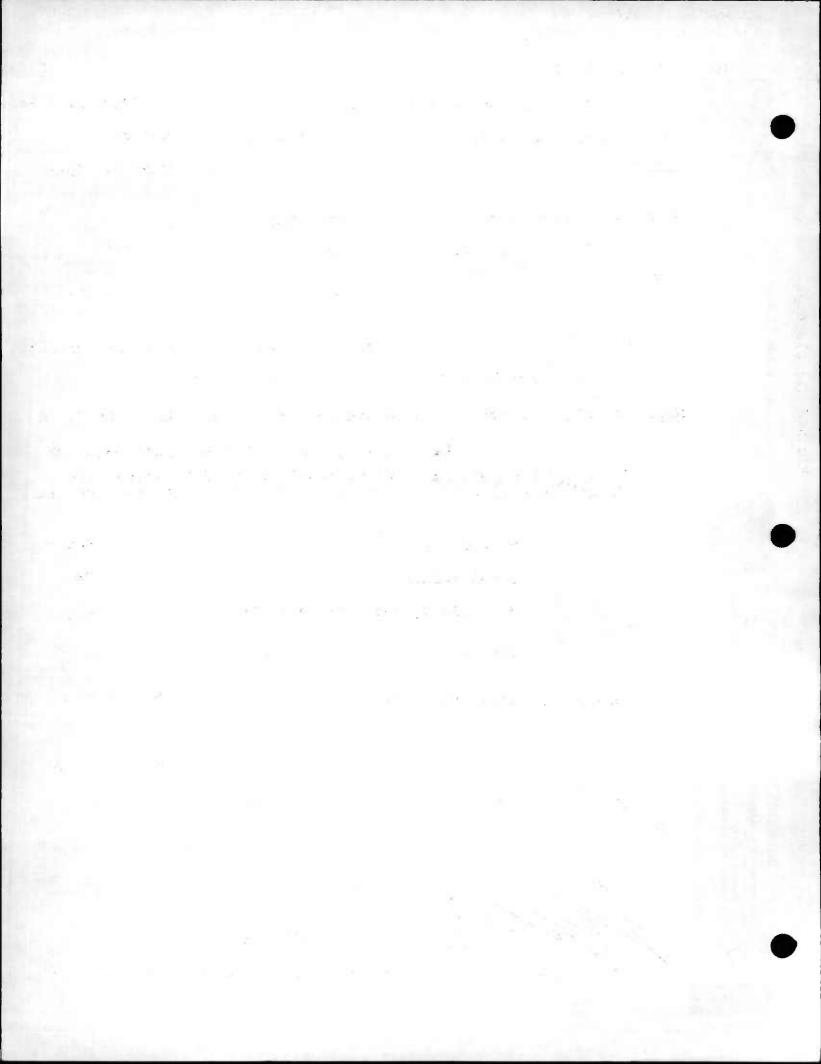
29d. Date signed (Month, Day, Year) 29c. License number 00053094

26. Place of Deeth (Check only one)

person who completed ceuse of deeth (Item 23e) (Type, Print)

Reinbold, 321 Bloomingdale Avenue Fredralsburg, MD 21632 31. Dete filed (Month, Day, Year)

State Registrar

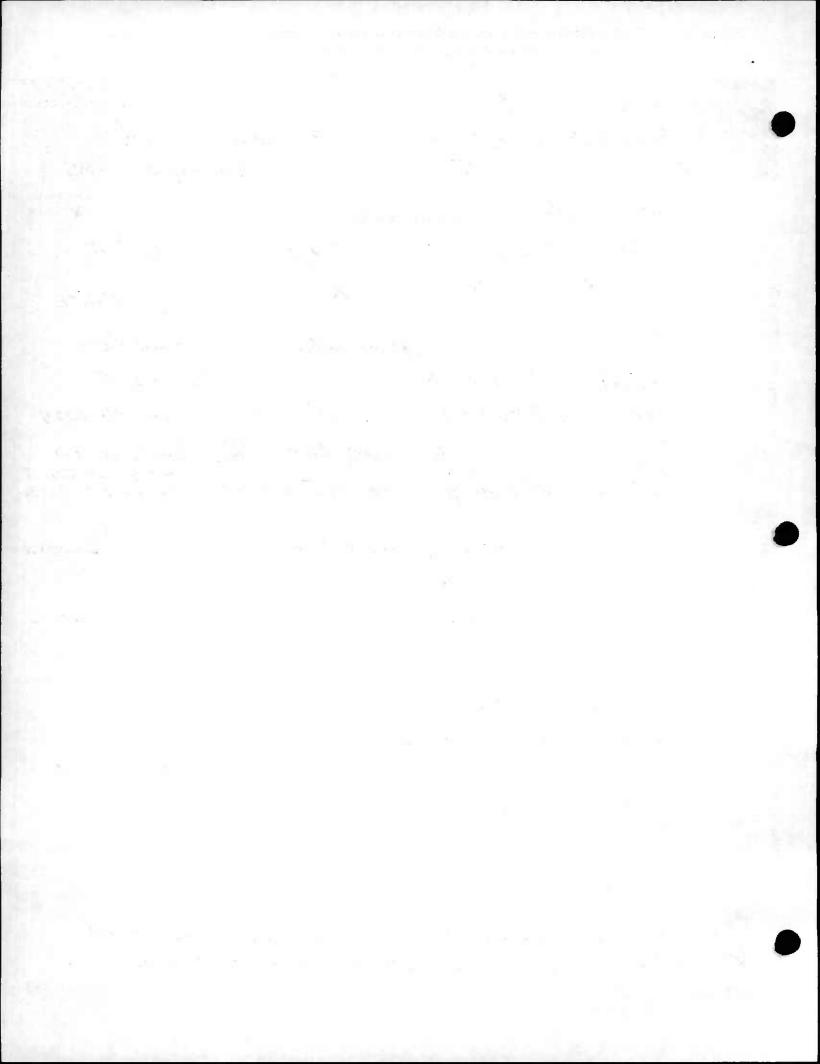


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Markowski Month **Physician** Freida 19:00 July 25,1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHN HONKINS

5. Social Sacurity Number 6. Sex BAUVIEW BALTI MORE If Undar 24 Hrs. 8. Data 7. Aga (In yrs. last birthday) 8. Data of Birth Month, Day Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2 F Months Days Hours 2/9-10-438 Usual Rasidance of Decadan Yrs. Director with the Maryland 10a. State 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show
important: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at
once. 10d. Insida City Limits 1 Nas 2 No MD. Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 305 MESTER 21231 ST. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marltal Status Baltimore, Maryland 21215-0020 1□ Yas 2DNo Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) OWN HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Surnama) Be WISNIEWSKI BRONZAH P 19a. Informant's Name/Ralationship (Type, 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) CHESTER BALTO. ARKOWSKI 305 S. 57 MD. 2/23/ 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from Stata JU4130 CEM 4 ☐ Donation 5 ☐ Othar (Specify) toLV ROSARV 1998 22. Nama and Addrass of Facility 401 5. CHESTER SI DAVID BALTO. MD. 2/2 23a. Part1. Entar the disease for complications that caused the death. Do not antar the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death Physician fmmediata Causa (Final disaasa or condition rasulting in daath) /Medical End stage live
Dua to (or as e consaguanca of) 2 weeks Examiner Physician/Medical Examiner Uremia week Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury Due to (or as a consaquanca of): Pancytopenia
Dueno (or as a consaquanca of): Division of Vital Records, P.O. Box 68760, that initiated avents rasulting in daath) Last or Attending Physician: The law requires that the death certificata Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobecco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown Arthritis Rheumatoid à 24b. Wara eutopsy findings evailabla prior to completion of causa of death? Completed 24a. Was an autopsy Coronary Artery Disease After this certificate has 1 ☐ Yas 2 X No 1 ☐ Yes 2 No Be 25. Was casa referred to medical axaminar? 26. Placa of Daath (Chack only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatiant 2 ER/Outpatiant 3 DOA 28c. fnjury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascriba how Injury occurred 1 Natural 5 Panding Investigation Injury daath. 1 ☐ Yas 2 🗆 No 2 Accident the within 24 hours aftar daatl To the Funaral Diractor: complataly filled in by the 6 Could not be datarmined 3 Suicide Location (Street and Number or Rurel Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida the Hospitai Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) and mannar as stated.

Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and manner stated. 29a. Certifian (Check only one) 29b. Signature end titla of cartifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) Gusting Eng Hui Wu, Resident July 25, 1998 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, Maryland John Hopkins Hospital, 600 North Worfe Street, Baltimore, Maryland 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State JUL 281998 Fulls Davidson

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**)y ames /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number, Examiner 605 Moreland Daltimore ave If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Sex 108 M 2□ F **Funeral** Months Days 214-07-9103 Vrs Maryland Director 12-10-10 Usual Residence of Decedent with the Merylend 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryle Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural; or items 23s or 28s-f show any injury or other traumatic event, its Medical Examinat must be notified at once. 1€Tes 2□No Director saltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? moreland AVENUE 21216 1405 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? - American Indian 11. Marital Status Black, White, etc. American 1 Never Married 2 Married 1 PYes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 No Specify: altimore, Maryland 21215-0020 py 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Collector Telephone Co. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SCOTT To ames W. Murrax Fannie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ave Baltimore, Md. 21216 605 Moreland Mrs Martha 20b. Place of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 □ Cremetion 3 □ Removel from State toaltimore, mo 4 ☐ Ponation 5 ☐ Other (Specify) 23. Name end Address of Facility. 21. Signatu e of Funeral Service Licens funeral Home Baltimore 2222 W. north Que 21216 plications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequenca of Division of Vital Records, P.O. Box 68760 Atr.W br. 16t Due to (or as a consequence of): signed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Was en eutopsy Completed ASCVO After this certificete has funeral director, page 2 1 ☐ Yes 2 ☑ No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

Funeral Director: After detely filled in by the fun 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner es steted. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and plece, and due to the cause(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 782 7128188 0 drys.c.a person who completed cause of death (Item 23a) (Type, Print) Av. Ballo und. 21211 Greenspring

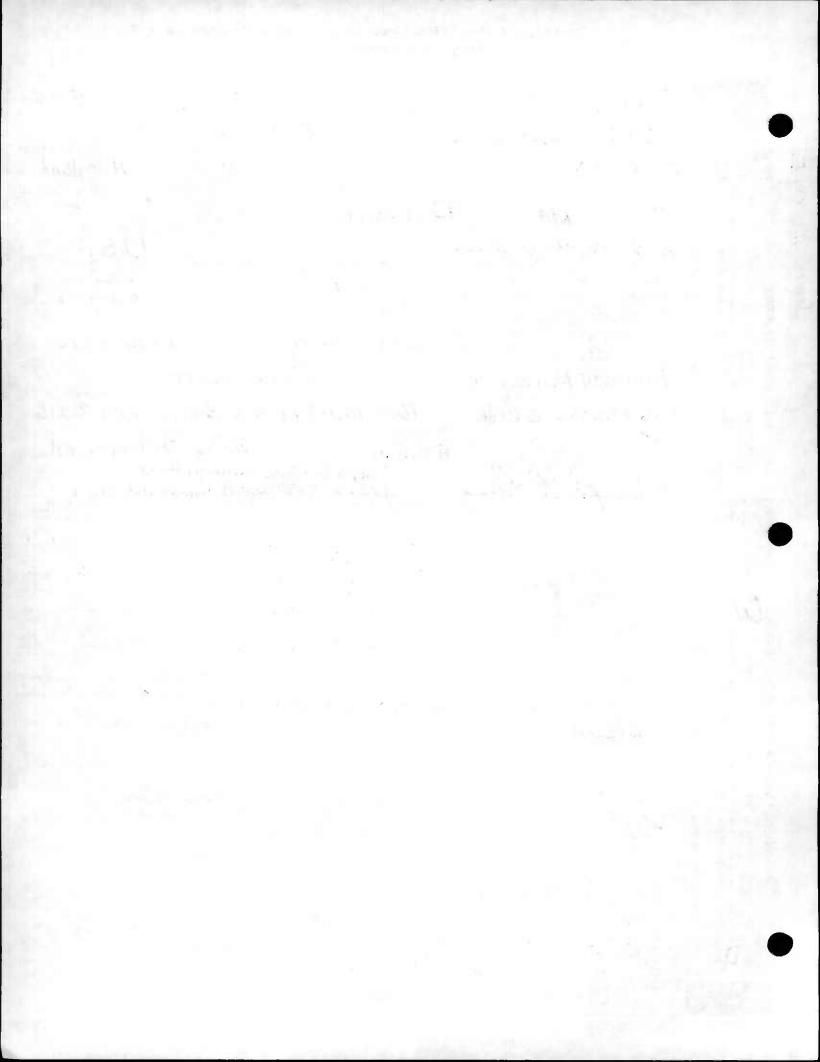
32 Registrare Signature

Registrar

State

Murray IIT

James



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#17 per FH G761 7/28/98 EW Reg. No. 1. Decedant's Nema (First, Middla, Last) 2. Dete of Deeth Month **Physician** JULY 22, MITTLEMAN 1998 1:00 PM ALBERT /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BALTIMORE 2608 SUMMERSON ROAD BALTIMORE If Undar 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Months Hours Yrs. 166-18-6870 MAY 3, Director 76 Usuel Residence of Decedent with the Marylend 10d. Inside City Limits 10a. Stete 10c. City, Town or Location 10b. County Show permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "netural", or items 23s or 28s-1 show any injury or other traumatic event, it is Medical Examinar must be notified at BALTIMORE BALTIMORE 1 Yes 20XNo MD Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21209 2608 SUMMERSON ROAD U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 XYes 2 ☐ No If Yes, Give Yeer or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE WWII Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) PROPRIETOR GROCERY STORE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be RUBIN Reuben MITTLEMAN BESS HOPKINS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) TARA MITTLEMAN (WIFE) BALTIMORE, MD 2608 SUMMERSON ROAD 21209 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20a. Method of Disposition tXXBurial 2 ☐ Cramation 3 ☐ Removel from State Oheb Shalom Memorial Park 7/24/98 REISTERSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Fecility 21. Signature of Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 WD 23a. Pln1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervet Between Onset end Death Physician Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical METASTATIC CANCER OF The prostate 1991 Examiner Due to (or es e consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): US6 65 Por signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed s cartificete has b director, page 2 s 2 1 No 1 Yes 2 No 1 ☐ Yas Attending Physician: r death. director, 25. Was cese referred to medicel examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturel injury 1 Yes 2 No 2 Accident 6 Coutd not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Direct 1 determiner: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted. 29a Certifier (Check 29c. Licanse number 29d. Date signed (Month, Dey, Year) 29b. Signet and title of celtifier 0 8915517 D28768 and MARID A. EISENberger 30. Name N d eddress of person who completed cause of deeth (Item 23e) (Type, Print) TZ MD 21287 N. WOLFE 600 BAUTIMONE 31. Data filed (Month, Day, Year) 32. Registrar's Signature. State ie Devidon Registrar

ultral edoners, again Final Piles the same of the sa

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 3083 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Virgil S. Moore, Sr. 25 July 1998 9:00 pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/07/1912 Birthplace (State or Foreign Country) 5. Social Security Number Days Months 1 ■ M 2 □ F Yrs Georgia 487-01-2805 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ■ No Maryland Baltimore. Rosedale 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8614 Wilenoak Court United States 21237 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - Americen Indian, Black, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Natalia B. Moore / Wife 8614 Wilenoak Court Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/29/98 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. Mars T. 9705 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung 3 months concer Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part il. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementin 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Covonary Artery disense 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 T Homicide

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Physician

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permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Merylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified at an other traumatic.

Physician

/Medical

Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or within 24 hours eff To the Funerel Di completely tilled in

Moore

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie Reley, uns

29c. License number

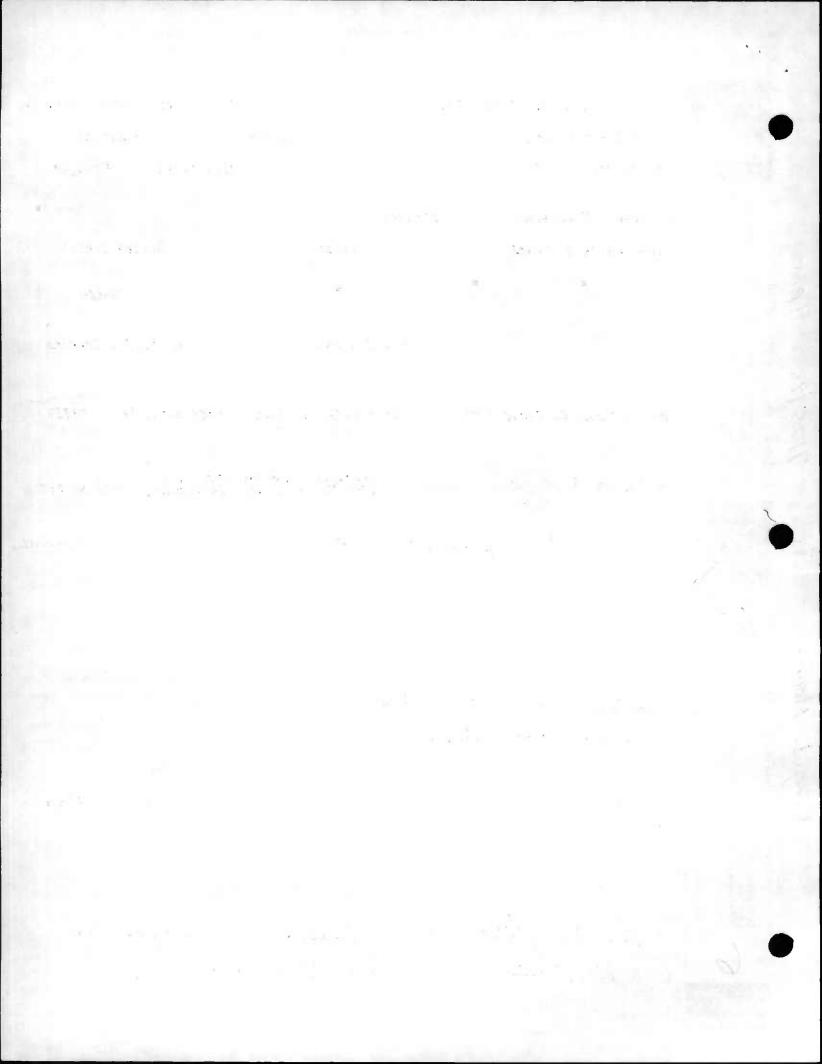
29d. Date signed (Month, Day, Year)

Jly26,1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 6-Bine

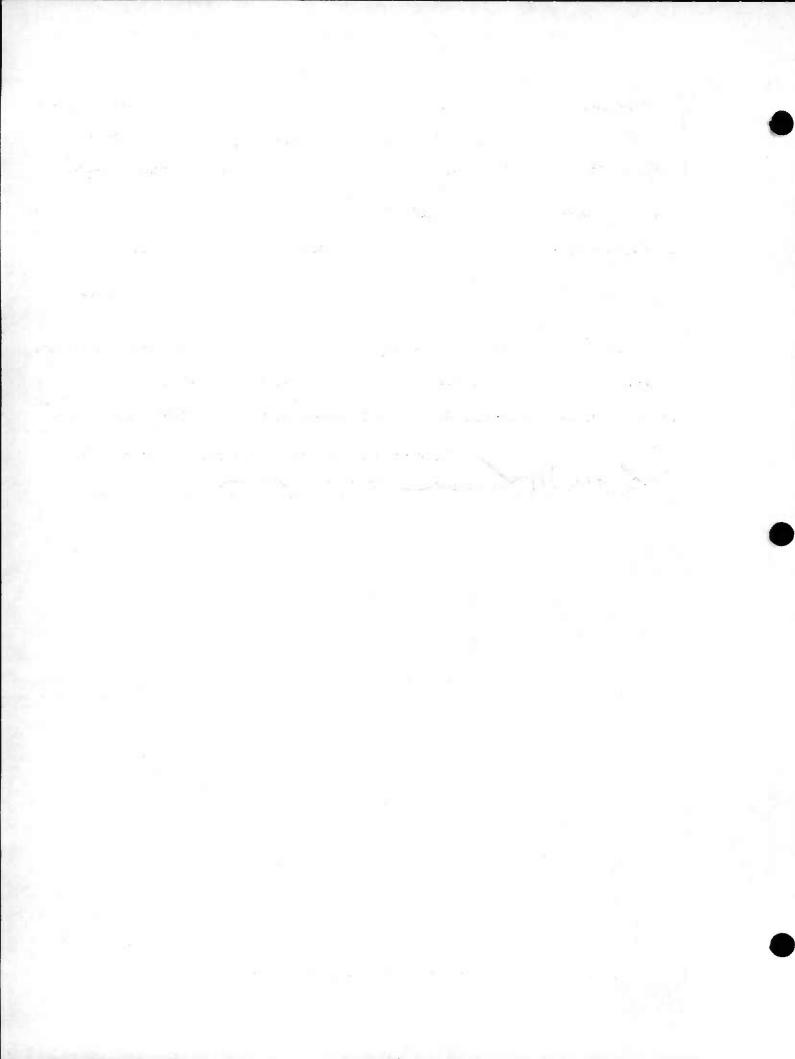
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31. Date filed (Month, Day, Year) JUL 281998 32. Registrar 5 grunde



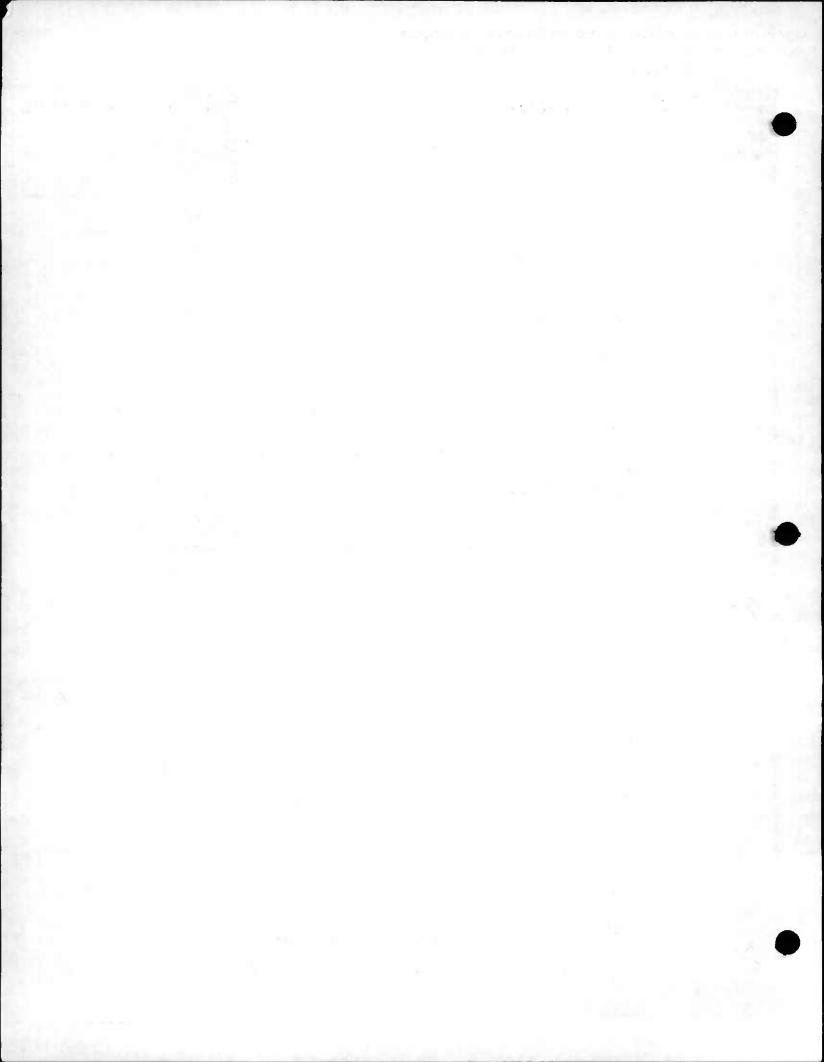
State of Maryland / Department of Health and Mental Hygiene 8 23084

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00 2		19a. Informant's Neme/Relationshi	p (Type, Print)		19b. Mailir	ng Address	Street	and Numb	er or Rura	l Routa Numi	ber, City or Town	ı, Stata, Zi	(p Code) 20879	
N F		Leslie A. Jacks	on/grand	daughte	r 18	416 H	one	ylocu	ıst C	Circle,	Gaither	sbur	g, MD	
= 0		20a. Method of Disposition		cor	ca of Dispo	sition (Name	a of ar piac	e)		Date	20c. Location	- City or T	own, Stete	
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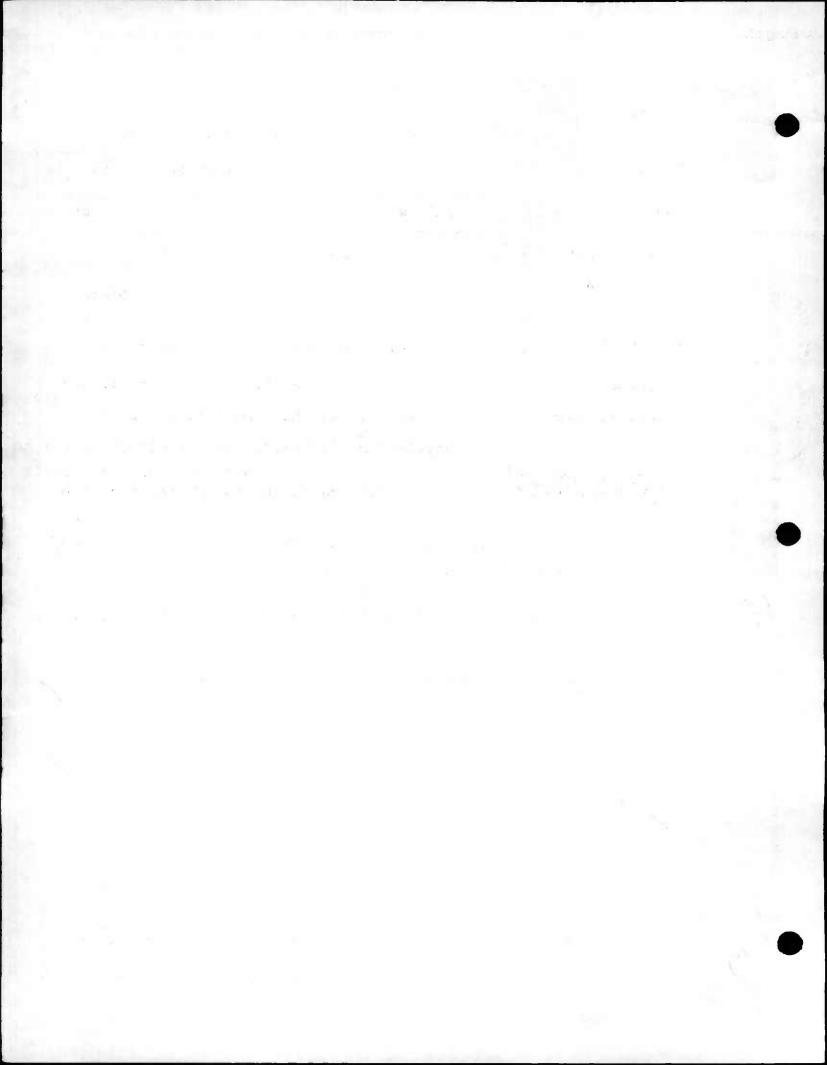
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Department of Health important: If Item 27 any Injury or other tr pace.		4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Cremation Society													
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State of Maryland / Department of Health and Mental Hygiene

	1	. Decedent's Name (First, Middle,	(ast)		Certif	icale of	Death	2. Dete of De	Reg. No.	3. Time of Death	
Physician /Medical Examiner			enn	"C 14	ospita	e i	4b. City, Town, or	Month /4	84 19	98 13 ⁵⁷ Am	
Funeral Director		234-44-8213	5. Sex 7. A 1 □ M 2√Ω F	ige (In yrs. I 69		Under 1 Year onths Days	If Under 24 Hrs Hours Min		h y, <i>Year)</i> 9.	Birthplece (Stete or Foreign Country) VA	
s i end 2 should be lined within 72 hours enter death with the Meryland Hygiene. Itam 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	1	Isual Residence of Decedent Da. State 10b. County Md N	A		Town or Location					10d. Inside City Limits 1/⊐XYes 2 □ No	
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		15. Decedent's (Specify only highest Elementary/Secondary (0-12) L 2th Grade	grede completed) College (1-4ol	5+)		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Self-employed			Beautic	tician	
	-	7. Father's Name (First, Middle, La Theodore 9a. Informant's Name/Relationship	Dalton		19b. Mailing A	ddress (Street	Marth	a	Maiden Sumama) Hall er, City or Town, Ste	criston de, Zip Code) 2120	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time of Death Month Yee **Physician** PLOWMAN LINNIE M. JULY 10:55 PM 24 1998 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c County of Death Examiner BALTIMORE HOPKINS BAYVIEW HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Sacurity Number 6 Sex 8. Date of Birth (Month, Day, Year) 10/10/19 9. Birthplace (State or Foreign Funerai Months Days Hours 1□ M 2 F PENNSYLVANIA 219-28-6401 78 Director Usual Residance of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1⊠Yes 2□No Funeral Director MD N/ABALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 244 S. EATON STREET 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritai Status Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Martiel Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatte event, the Madical Examine 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: À 3. Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE CROTSLEY GRACE CORNIELUS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONNIE HUNDT/ DAUGHTER 2616 E. MADISON ST. BALTIMORE, MD. 21205 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1₺ Burial 2 ☐ Cremation 3 ☐ Ramoval from State CEDAR HILL CEME. 7/29/98 4 ☐ Donation 5 ☐ Othar (Specify) BROOKLYN PARK, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility KACZOROWSKI FUNERAL HOME P.A. a 000 whe 1201 DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart tailura. List only one cause on each line. Approximate Intarval Batween Onset and Death Physician /Medical Immediata Causa (Final HEART FAILURE YEARS disease or condition resulting in death) CONGESTIVE Examiner Due to (or as a consequence of): Examiner 4 YEARS Myocardial INFARCTION Saquentially list conditions, if eny, leading to immadiata cause. Enter Undarlying Causa (Disaasa or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ACUTE RENAL FAILURE Records. þ 24b. Ware autopsy findings evailable prior to completion of cause of daath? 24e. Was an autopsy performed? Completed PNEUMONIA paga 2 has 2 XNo 1 ☐ Yes 2 ☐ No 1 Yes ISCHEMIC Division of Vital BOWEL or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xtnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Panding invastigation deeth. 1 Yes 2 No 2 Accident 24 hours eftar deef Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 6 4 Homicida filled in ! 1 Certifying Physician: To the best of my knowledga, daath occurrad at the tima, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurrad at the tima, data and place, and due to the causa(s) and manner stated. 29a. Certifier Medical completaly (Check only one) within 2 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

JUL 281998

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30. Name and address of parson who completed causa of death (Item 23a) (Type, Print)

32. Registar Signature Medical CENTER

Julian Superior Pendale

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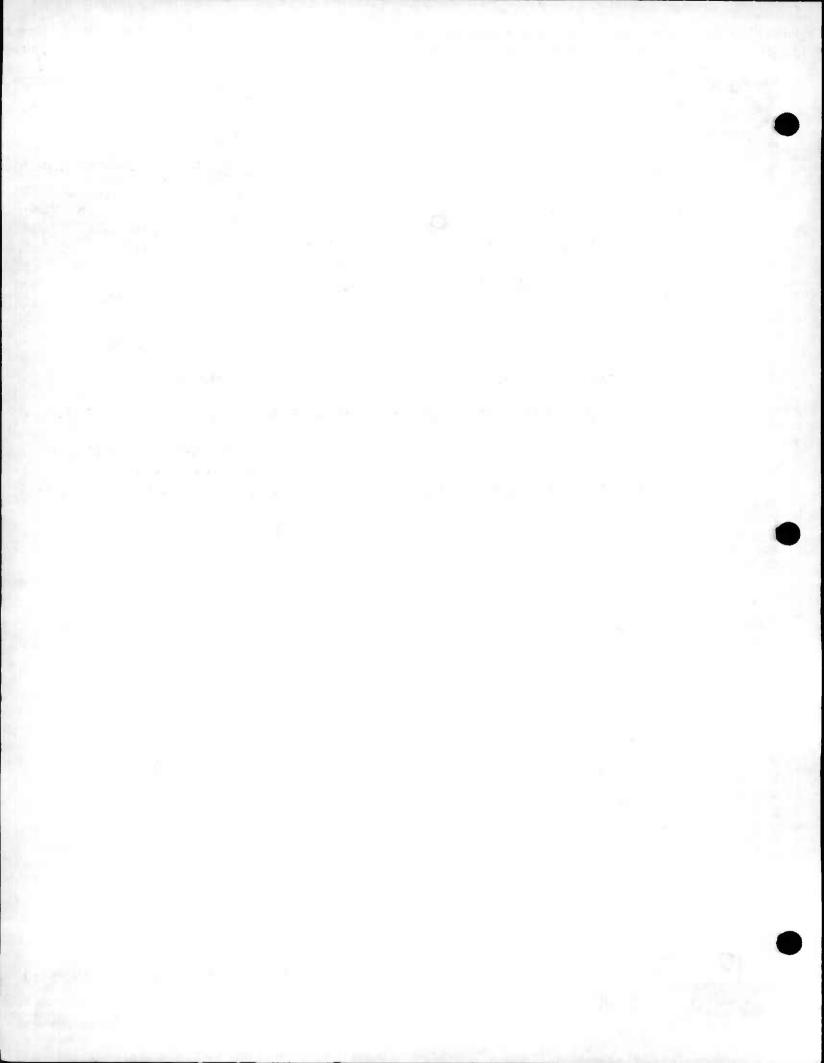
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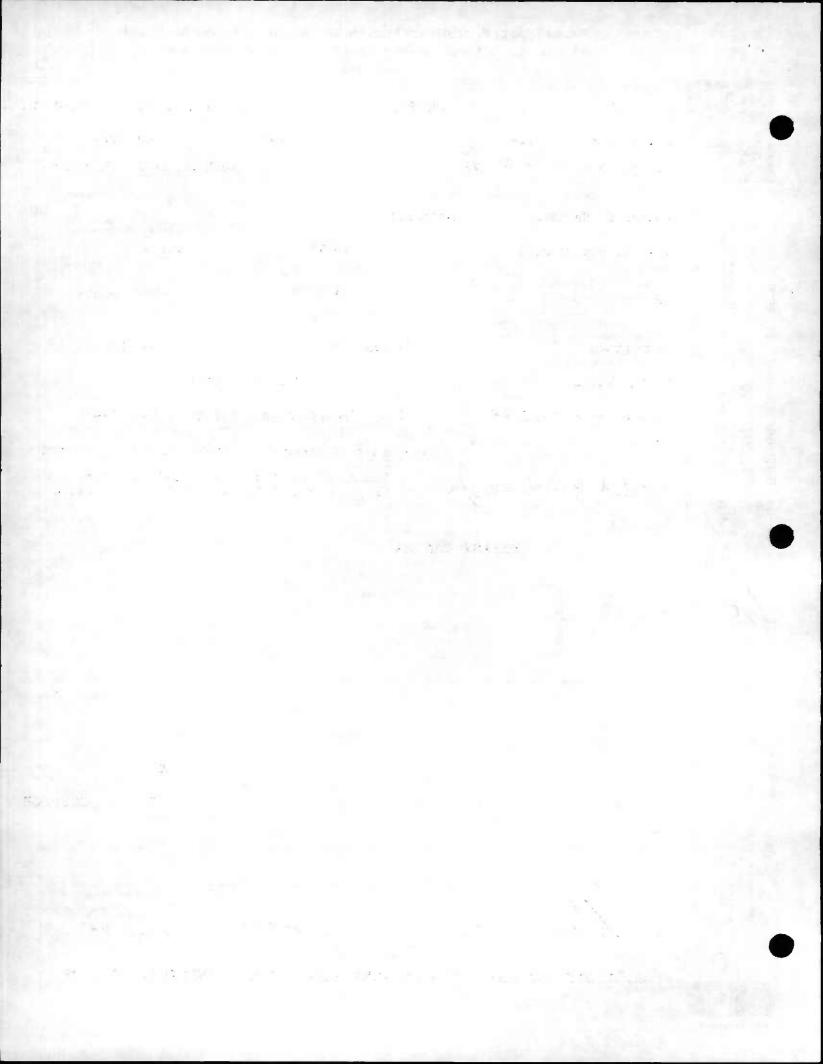


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Yee **Physician** 9:00 p.m. DORIS E. PETERS 24, 1998 JULY /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Towson Stella Maris Hospice Baltimore 8. Dete of Birth (Month, Dey, Yee March 14, If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplece (State or Foreign Çountry) 7. Age (In yrs. lest birthdey) **Funeral** Yeer) 1920 Deys 1 □ M 2 🗓 F Maryland 78 Vrs Director 216-03-3278 Usual Residence of Decedent the Maryland parmit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-I show any injury or other traumatic event, the Medical Examination of moties at ponte. 10c. City, Town or Location 10d. tnside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☒ No Director Maryland Harford Abingdon 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 2612 Colpepper Road 21009 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Retail Sales Salesperson 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George Walker Mary Eva Brcak 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2612 Colpepper Road, Gail Garriss (Daughter) Abingdon, MD. 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. 7/28/98 Dundalk, Maryland 22. Name and Address of Fecility 21. Signature of Funerel Service Licenses Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) (Meditta) e BREAST CANCER Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 thet initiated events resulting in deeth) Lest Due to (or es e consequence of): The law requires that the deeth certificate signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? should b Completed 24e. Wes en eutopsy r this certificata has rai director, paga 2 1 ☐ Yes ¾☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Be 25. Wes cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) HOSPICE2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: Aftar 5 Pending Investigation 1 Neturel 2 Accident 1 Yes 2 No rector: 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours efter de To the Funeral Directo completaly filled in by the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner steted. edicai 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end t certifie 29c. License number deloca 10) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093 EDDIE NAKHUDA, 31. Date filed (Month, Day, Yeer) JUL 2 8 1998 State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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29a. Cartifiar (Check only (Check only 2) Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.	50(s)			
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1 (whard L. Lmthraum 131826 7-23-98				
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)				
RICHARD L. LINTHICUM M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204				
31. Data filed (Month, Day, Year) 32. Registrars signature Strar 31. Data filed (Month, Day, Year) 32. Registrars signature Strar				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10f perFH G761 7/28/98 EW 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Month 3. Time of Deeth Yee **Physician** JULY 25, 1998 EVA RAPKIN 1:00am /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** TOWSON HOSPICE OF BALTIMORE-GILCHRIST CENTER BALTIMORE If Under 24 Hrs. 8. if Under 1 Year Date of Birth Birthplece (State or Foreign
 MARYLAND 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Months 212-82-8267 1 M 25 F 84 Yrs Director Usuel Residence of Decedent the Maryland 10a. Stete MARYLAND 10c. City, Town or Location BALTIMORE 10d. inside City Limits item 27 is marked other than "natural", or items 23e or 28a-f show other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2125 21215 7121 PARK HEIGHTS AVE, APT. 605 USA Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Raca - American indien. Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other treumatic event, the Messengone." 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 12 OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be SAMUEL PINSKY ROSE KRAMER 0 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Retetionship (Type, Print) MR. HARVEY RAPKIN (SON) 2207 SHEFFLIN COURT BALTIMORE, MD 21209 Baltimore, 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removet from Stete ARLINGTON-CHIZUK AMUNO 7-26-98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of far erel Service Licensee 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD BALTIMORE, MD 21208 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical The 16 years Examiner Due to (or as a consequence of): Examine Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that britished execute. Due to (or es e consequence of): physician and Physician/Medical thet initieted events resulting in deeth) Lest 96 Due to (or es e consequence of) USB 25 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 Probably 4 Unknown R 1 Yes 2 No signed t þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 should Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medicel 26. Plece of Deeth (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ò 1 Certifying Phyalclan: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and tilland certifier pleted ceuse of death (Item 23e) (Type, Print) 30. Name and N. Charles St. Bolto, Md 21204 6 Binc 6701

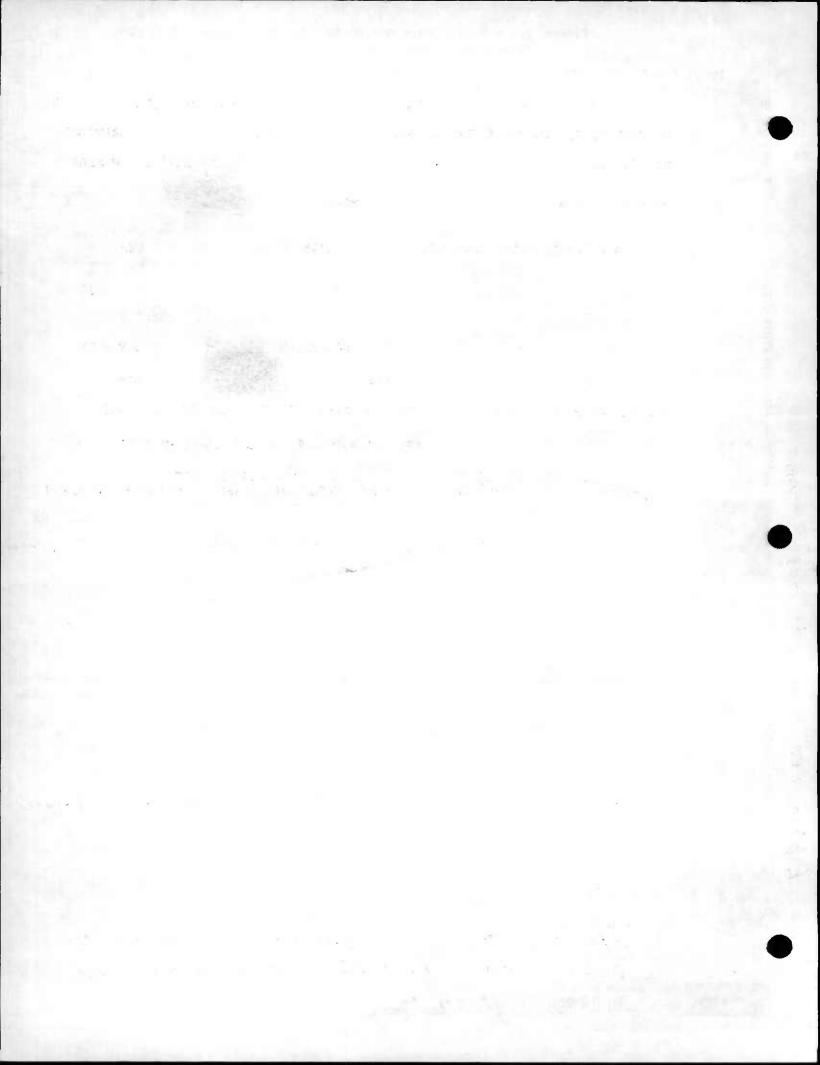
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32 Registrer's Signeture

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29c. License number

AS 240 2321

2401 West

Baltimore,

29d. Date signed (Month, Dey, Year)

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Cloly

Belvedere

Maryland

State Registrar Ugochi

31. Date filed (Month, Dey, Year)

JUL 281998

29b. Signature and title of certifier Internal Medicine Resident

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

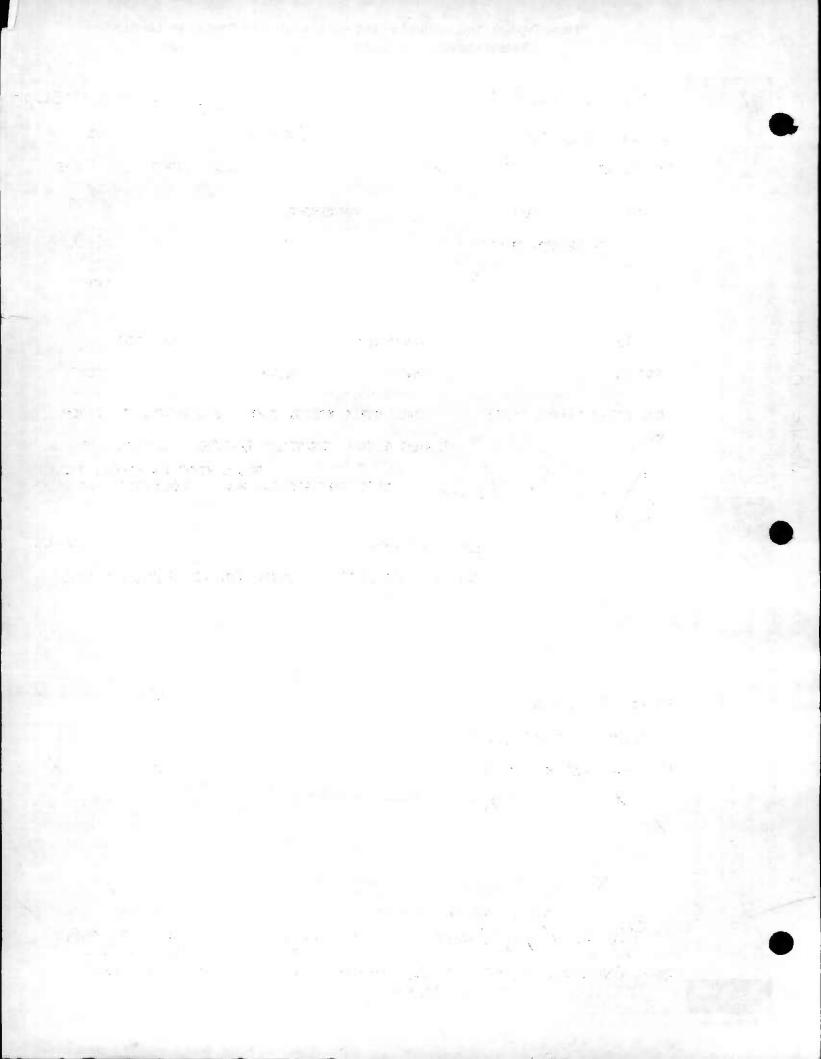
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32. Popintrar's Signature

MD PhD, Sinai Hospital,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Dev Month **Physician** Martha C. Rotunno July 21, 1998 8:40 PM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Eastpoint Nursing Home Baltimore 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs.

Months | Devs | Hours | Min. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys 10M 20F Yrs Director 218-07-7933 April 25,1903 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10e. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Dundalk Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2206 Searles Road 21222 United States Funeral Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specity: à 3 ☐ Widowed 4 € Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Clerical 10 Years Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Caulfield Antoinette Pensker To 19a. Informent's Name/Reletionship (Type, Print) Daughter 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Dolores A. Blachowicz 2206 Searles Road Dundalk, Maryland 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion /5 ☐ Other (Specify) 7/24/1998 Holy Rosary Cemetery Dundalk, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. al Service Lib 21. Signature of Fune 7922 Wise Ave. Dundalk, Maryland mina 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** De Vasculer Accident Immediate Ceuse (Final disease or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy this certificate has ral director, page 2 2) No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: after death. 25. Wes case referred to medical Be 26. Piece of Death (Check only one) examiner? Other: 42 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deet 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et 4 Work? Certification: After 5 Pending investigation 1 Maturel injury 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner steled. edicai 29a. Certifier 29d, Dete signed (Month, Dev. Year) 29c. License number 29b. Signature end title of certifie h leted ceuse of deeth (Item 23e) (Type, Print) 30. Name end eddress of person 9512 HARFORD RD Baltimore MOHAMMET Mn 32. Registrar's Signature Mariason-Mandell 31. Date filed (Month, Day, Year) State

Registrar

JUL 281998

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month **Physician** 5:45 PM Frederick John Stout SUL /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner ST. AGNES HOSPITAL BALTIMORE If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** Months 1⊠M 2□ F 219 18 5705 Vrs Director Maryland Nov. 14, 1926 Usual Residence of Decedent 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits tem 27 is marked other than "natural", or tema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yas 2 No Baltimore Directo Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 905 Washburn Avenue 21225 U.S. Funeral permit. Peges 1 and 2 should be filed within 72 hours efter dean Depertment of Health and Mentel Hygiene. Important: If Itam 27 is marked other than any injury or other traumers. 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - Amarican Indian, Bleck, White, etc. 1☑ Yes 2□ No Korean if Yes, Give Year or Dates: Conflict 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic Paint Company 8th 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Leona Marski Frederick J. Stout Sr. 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 21225 Deborah Schline / daughter 218 Riverview Road 20b. Place of Disposition (Name of camatery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7/30/98 Crownsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) State Veteran Cem. 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ranususki publications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting In deeth) LIVER METASTASIS /ivicaicai mo Examiner Examiner UNDIFFERENTIATED STALL CELL CANCER Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24a. Wes en eutopsy 1 Yes 20 No 1 ☐ Yes 2 No certificate Division of Vital 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident efter deat Director: 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 6 24 hours Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signeture end title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Yeer) Way MD 30. Nema end eddress of person who completed cause of death (Item 23e) (Type, Print) XOI HOSP - 900CATON AUG VIOLETA - ST AGNES 32. Registrar's signatures 31. Dete filed (Month, Day, Yeer) State 281998

Registrar

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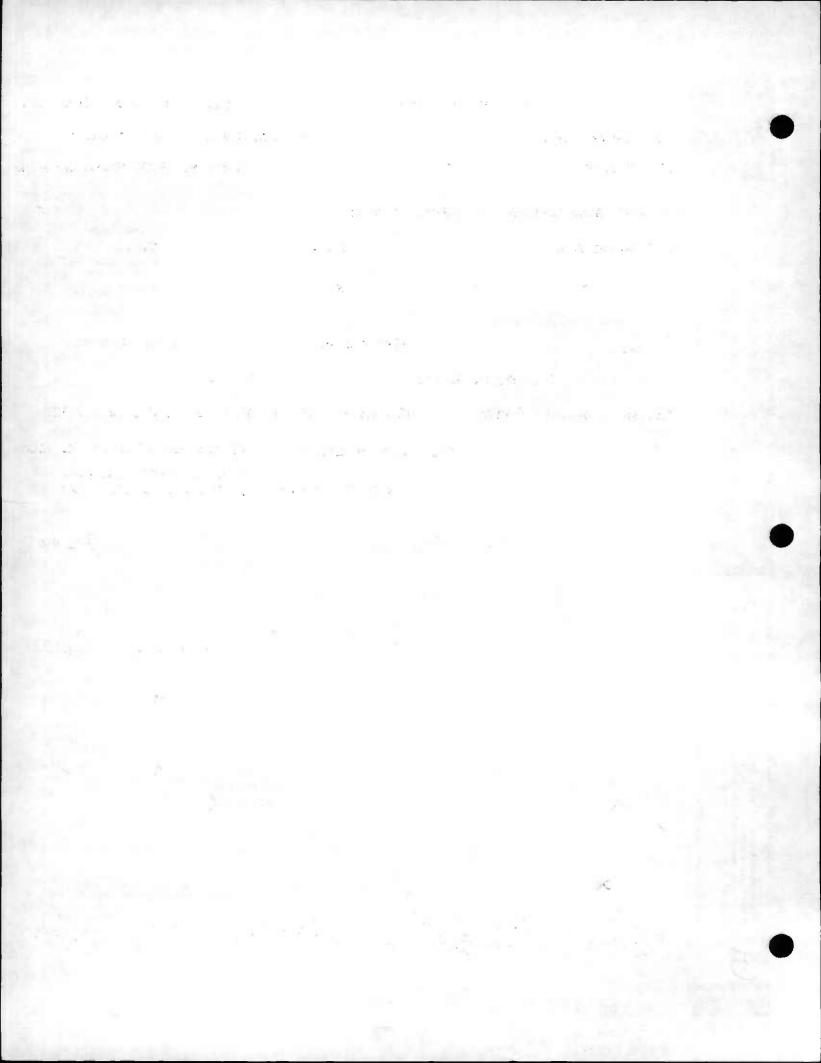
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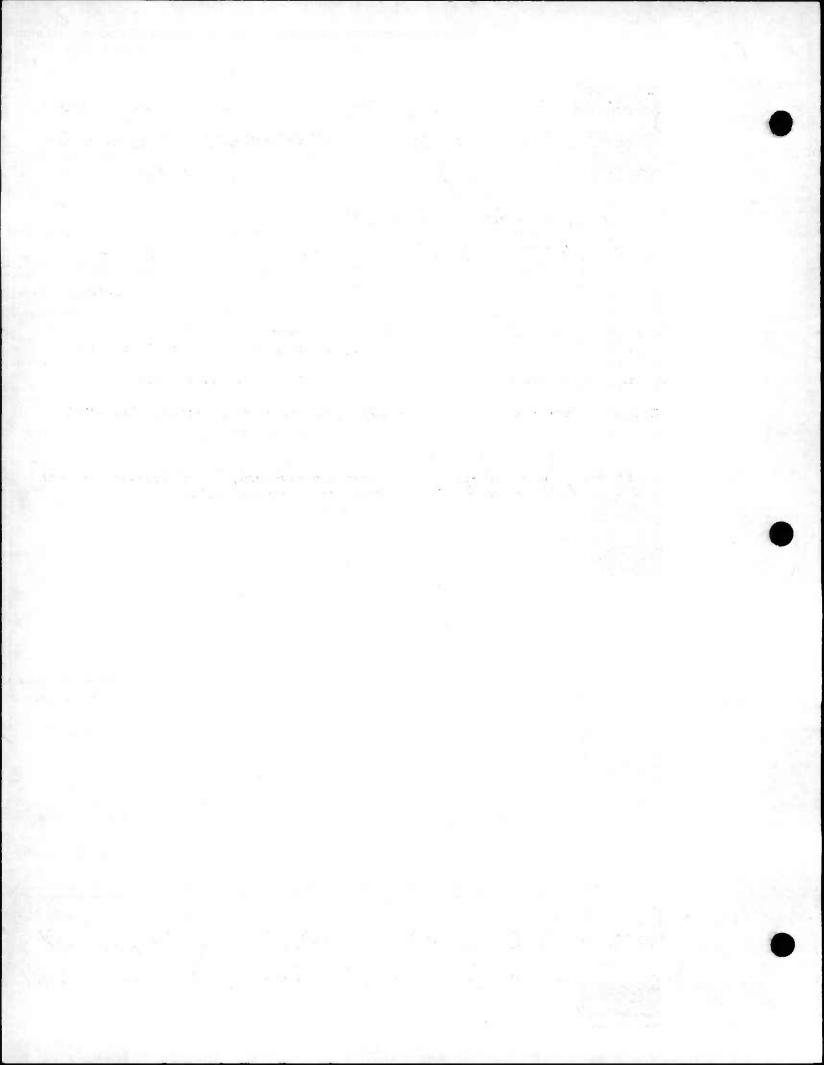
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** John Wesley Stewart 24 1998 5:00 P.M. July /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 245 Carvel Road Riviera Beach Anne Arundel If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Dey, You March 9, 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 11X M 2□ F 212 26 7159 Yrs 1929 69 South Carolina Director Usual Residence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Importants if Items 23s or 28s-f show any fujury or other traumatic event, in Mental Promise than "natural", or items 23s or 28s-f show any fujury or other traumatic event, in Medical Examiner must be notified as 1 ☐ Yes 2 1 No Anne Arundel Riviera Beach Director Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 245 Carvel Road 21122 U.S. Funeral Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Electrician Sugar Industry 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Lucy Vick Burrell H. Stewart 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lilian E. Stewart / wife 245 Carvel Road Riviera Beach, Maryland 21122 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 7/27/98 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway raminouster Baltimore, Md. 21225 23e. Part1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 2 mos. **Examiner** Due to (or es e consequença of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequence of) dlan Carcinana use es 09 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 20 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy peeu hes page 2 2 2 No 1 Yes 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 22 No 2 1 Inpatient 2 ER/Outpatlent 3 DOA this funeral 27. Manner of Death 28e, Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After Neture 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homleide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end,manner stated. 29a. Certifier Medical pletely (Check only one) within 2 the 29b. Signeture and title of cartifier 29d. Date signed (Month, Dey, Yeer) who completed cause of deeth (Item 23e) (Type, Print) deddress of person 1600 C RAIN Hwy. Suite 602 Clen Burnie. KUSSE 31. Date filed (Month, Dey, Year) State cha Davidson 281998 Registrar



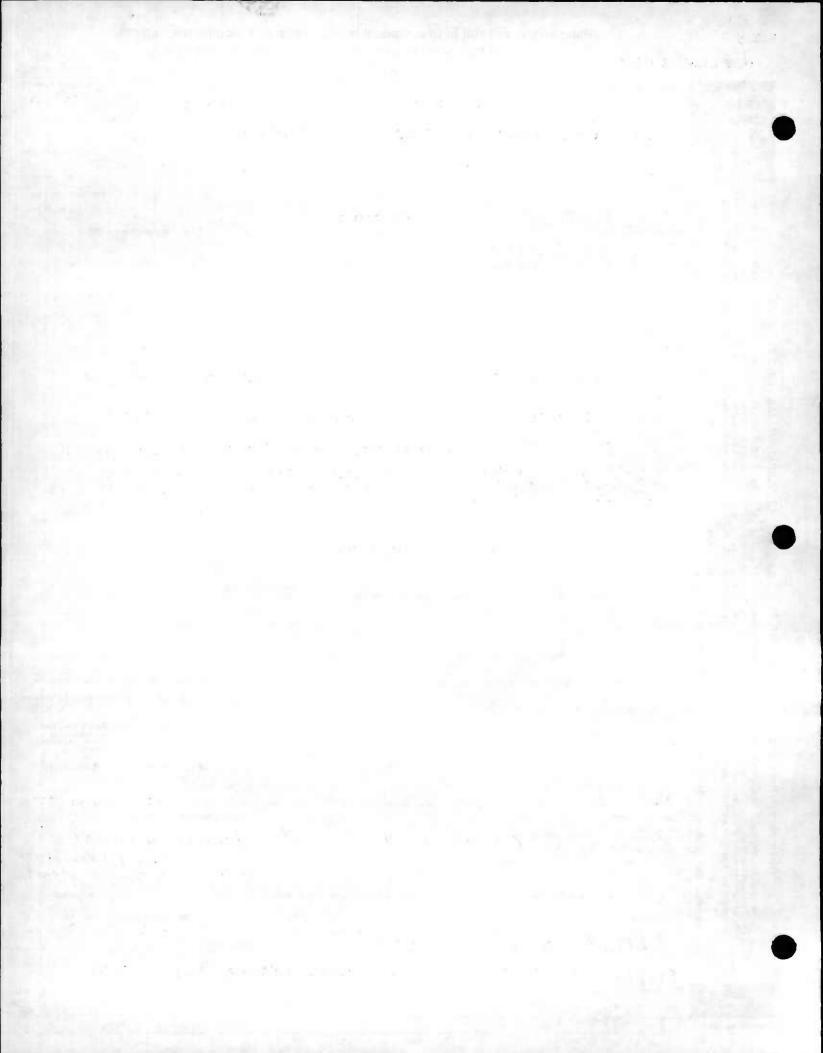
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Physician /Medical Examiner	1	KOBERT (le. Facility Neme (If not institution, gh	ye street end number)	Snyc	ER	4b. City, Town, or	July	16, 1998	1:50			
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or 28a-f show		10e. Stete 10b. County Anne A	rundel 10c.	City, Town or Lo	. /	· S			10d. Inside Cit			
with the Market state of Director	5	0e. Street end Number	T DOW		10f. Zip C	21403		10g. Citizen of V	Vhet Country?			
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Attending Physician: The law requires that the death cartificate be asscuted trideath. sctor: After this cartificate has been signed by the attending physician and by the funeral director, page 2 should be datached for use as the burial-transit iffication: To Be Completed by Physician/Medical Examin	5 -	2 -	5 -	or in out of organization of the control of the con	on mouning to death but not n	esoung in the d	idenying cac	se given in Perts,		Yes 2 No	3 Probably 4 L	
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		examiner? 1 Yes 2 No 7. Menne of Deeth 1 Meture 5 Pending investigatio	Hospitel: 1 Inpatient 2 28e. Dete of Injury (Month, Dey Year)	Other	sing Home 5 Aesidenca 8 Other (Specify) 28d. Describe how injury occurred							
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	K.S HIN RAYMON	ND SHIRKLEY	State of	Marylan		artment o			Mental Hyg	iene 9 8	3 2	3096			
	Physician Medical	1. Decedant's Nama (First, Middla, Last) John Raymond Shirkley								Day Year		3. Tima of Death 9:55 AM			
	Examiner	4a Facility Nama (If not institution, 21ST & ST.PAU	ocation of Deeth	4c. County	of Deeth										
	Funeral Dírector	UNK.	UNK. 154 Yrs. Months Days Hours N							^{Year)} 1944	9. Birth Cou UNK .	placa (Stata or Foreign ntry)			
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215-0020 thin 72 hours after dea en *natural; or items Medical Examiner on Apleted by Fune	10e. Street and Number 342 E. 25th	Straat			10f. Zip Co	da 2121	1	0g. Citizan <i>of</i> US		ntry?					
	11. Marital Status 1 Navar Marriad 2 Marrie 3 Widowed 4 Moivorced	12. Was Dece Armed For	as Decedent Ever in U,S. med Forcas? □ Yas 3□ No Yas, Give 1□ Yas 2□ 1□ Yas 2□			of Hispanic Cuben, Mex	Origin? (S Ican, Puart	pacify Yes or No- o Rican, atc.)	14. Ra	can Indian, atc.					
	15. Decedant's (Specify only highast Elamantary/Secondary (0-12) UNK •	Education	16a. Decedant's Usual Occupetion (Give kind of work done during most life. DO NOT use retired) Welder			nost of wor	king	16b. Kind of B							
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ylar			John Raymond Shirkley						atherin						
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	4 Donation 5 Othar (Spe	ecity)	Met		ematory				Baltin						
Ra	Deper Depe Impo	21. Signature Tunara Service Uranas 22. Name and Addrass of Facility Ciety of Maryland, 22. Name and Addrass of Facility Cremation Society of Maryland, 299 Frederick Rd. Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
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Box.	deeth ed for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contributs to the cause of death?					
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	within 2 To the comple	29b. Signetura end title of cartifiar	and mann	acl	Z, M	po	.C.M.E		2	9d. Data signa		Day, Year) 1998			
		30. Nama and eddress of person w	Rade	172	111	Penn St	reet,	Balti	imore, Ma	ryland	2120)1			
	State Registrar	31. Data filed (Month, Day, Year)	1998 32. R	gistrar's Signa	itura 7	- 100 a									



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State of Maryland / Department of Health and Mental Hygiene q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth MonthLY 1998 6:00am **Physician** CHARLES SALSTEEN, JR. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Hours 1 1 M 2 □ F Director Mar. 18, 1920 R.I. 036-20-4238 Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 X No 7 is marked other than "natural", or items 23s or 28s-f traumatic event, the Medical Examiner must be notifis Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 늄 USA 21204 33 Chiara Ct. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Merital Stafus Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 □ No If Yes, Give Year or Dates: WW-II 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Hoods Dairy Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mental Lydia Ann Dodd Charles Salsteen, Sr. 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 33 Chiara Ct. Towson, Md. 21204 of Health Diane O'Conor/neice 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/28/98 Towson, Md. Hilltop Service Corp. 21. Signature of Funeral Service License 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical · LEREBRAL VASCULAR THROMBOSIS Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last Due to (or as e consequenca of): Records, P.O. Box 68760 The law requires that the death certificate in Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown URINARY TRACT INFECTION signed to þ 24b. Were autopsy findings evallable prior to completion of cause of death? Completed 24a. Was an autopsy performed? And SEPSIS. n this certificate hes eral director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after deeth. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpaflenf 3 □ DOA funeral 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 3 Suicide 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29c. License number
D - 1 2 8 4 9 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Oblad in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADI. M.D. 7600 OSLER Dr. TOWSON. Md. 21204 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

Julia Davidson-Randoll

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Registrar

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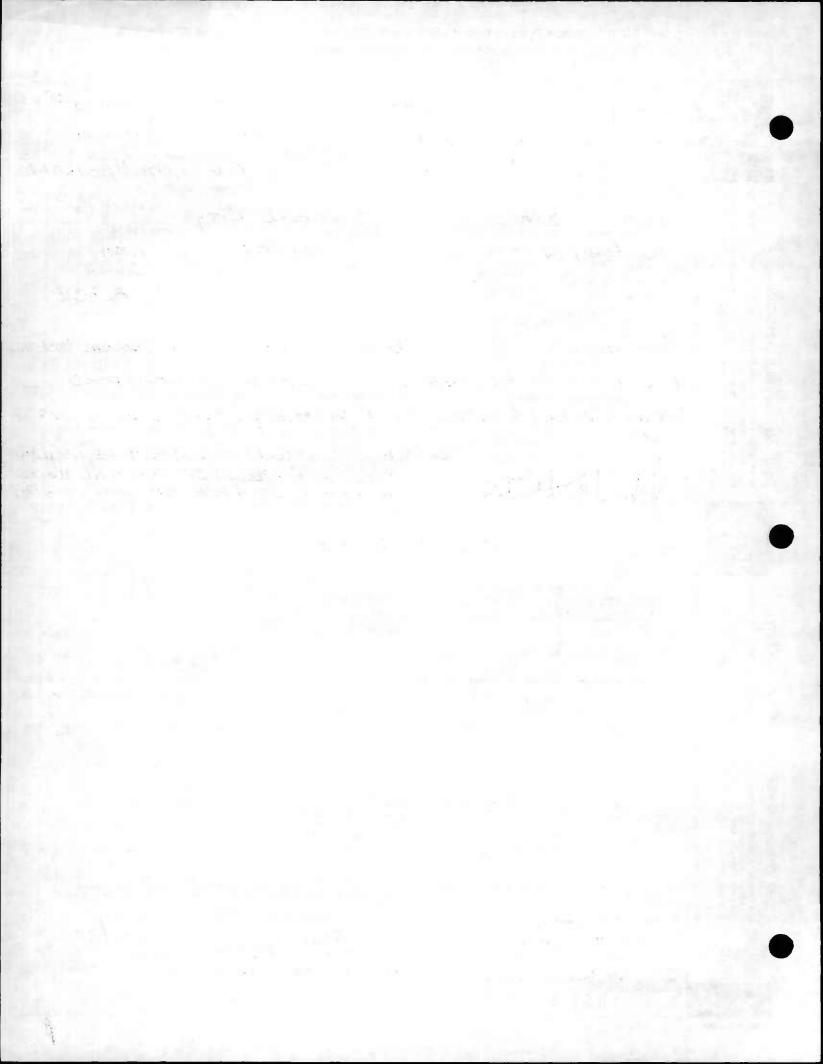
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Data of Daath 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day 45 AM Month **Physician** SAMUEL 98 Reverly 25 /Medical 4e Facility Nama of not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner BALTIMORE HOSPITAL BALTIMORE 5. Social Sacurity Number of Mary Isnel If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthday) Birthplece (Stata or Foraign Country) **Funeral** Days Months 1□M 20 F Hours 217-40-9630 Yrs. AUG. 08,1941 Director MARY Usual Rasidance of Decedant with the Marylend 10a. Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23s or 28s-f show any Injury or other treumstic event, the Medical Examines must be notified as 1 Yes 2 No Directo BALTIHORE MARY LAND 10e. Street and Number 10g. Citizan of What Country? STREE 1 21201 USA. Funeral 116 12. Was Decedant Evar in U,S. Armed Forces?, 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status Nevar Married 2□ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: BLACK Š 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 +H GRADE MD, GENERAL IET AID 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be ROBINSON KICHARD 2 EMMA LANGFORD 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 1224 N. MONASTERYAVE, BALTIMORE, MD. 2/229
lace of Disposition (Nama of Data 20c. Location - City of Town, Stela SHELIA ROBINSON SISTER 20b. Placa of Disposition (Nama of cematary, cramatory or other placa 20a. Mathod of Disposition 1 Buriel 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 7-31-98 BALTIMORE, MARYLAND WOODLAWN CMETERY 22. Nama and Addrass of Facility JOSEPH H. BROWN JR. FUNERAL HOME te of Funeral S FULTON AVE. BALTIMORE, HD. 21217 2140 N In . Entar the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, ock, or heart fellure. List only one ceuse on each line. Approximata Interval Betwee Onset end Daa **Physician** Immediate Cause (Final disaase or condition rasulting in daath) /Medical Anoxic Enceph = lopATHY Examiner Due to (or es e consaguança of) Physician/Medical Examiner end I-transit The law requires that the death certificete be executed Sequantially tist conditions, if eny, taeding to immadiate causa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequenca of): ettending physician el for use es the burial-P.O. Box 68760. that initiated avents rasulting in death) Last Due to (or es e consequança of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Wara autopsy findings evellable prior to complation of cause of death? Completed 24a. Was an autopsy performed? After this certificete hes funeral director, pege 2 1 ☐ Yas 2 XNO 1 ☐ Yas 2 No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this cartifice completely filled in by the funeral director, I 25. Was casa rafarrad to medical axaminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) P 1 Yes 2 No 1 1 Propagation 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 X Natural 2 Accident 5 Panding invastigation 1 Yas 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Acertifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, end due to the ceuse(s) end mannar es steted.

| Description of the d 29a. Certifier edical 29b. Signatura and titla of certification 29c. Licanse number 29d. Data signad (Month, Day, Year) 98 PIOZZI 25 JAMES, WANG 30. Nama and andress of person who completed causa of daeth (Item 23a) (Type, Print) MD 21201 South Greene BALTIMORE Street 32. Régistrar's elignatura 31. Data filed (Month, Day, Year) JUL 281998 State Registrar

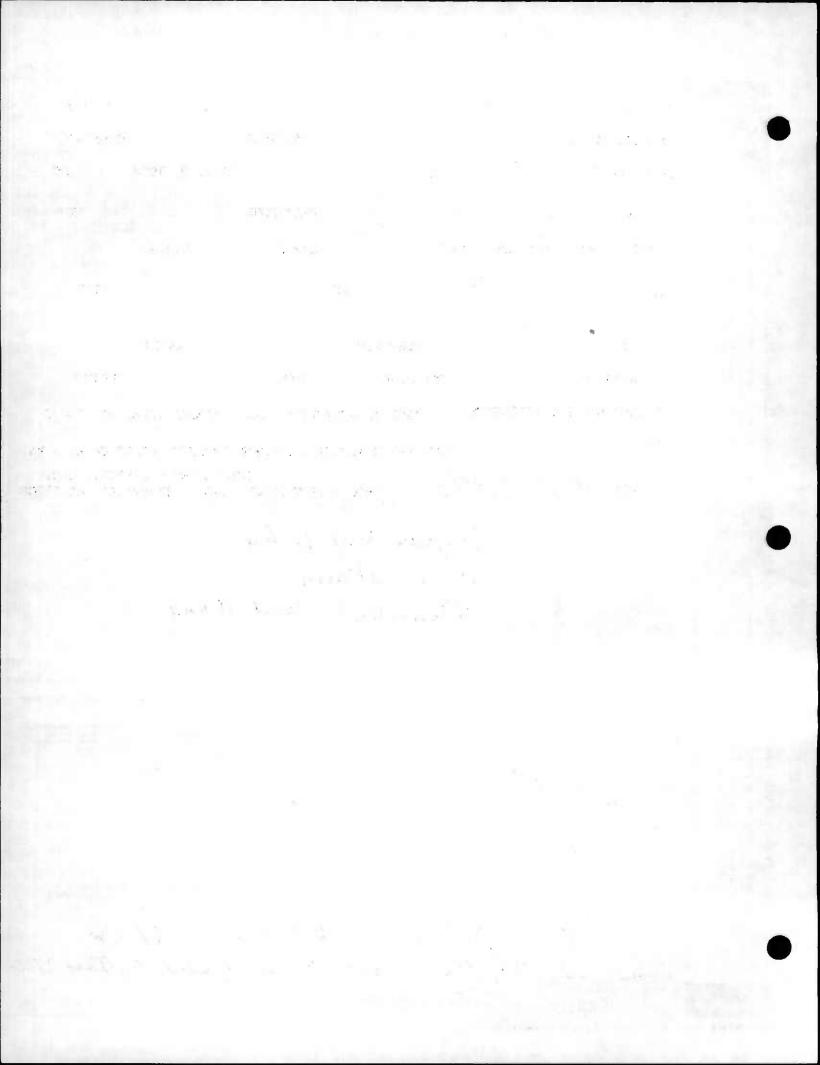
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:350 N SCHIFF ROSE TULY 8 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HURWITZ HOUSE BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1□M XXF Yrs. Director 93 578-54-5722 SEPT. 9, 1904 MD Usual Residence of Decedent with the Maryland 10d. inside City Llmlts 10a. Stete 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at XXYes 2□No BALTIMORE MD N/A Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2500 W. BELVEDERE AVE. 21215 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: WHITE by ¥X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 HOUSEWIFE OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be **ABRAHAM GOLDBERG** LURIE **ANNA** 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR LAZARUS (GRANDSON) 1203 TOWNSHIPLINE ROAD PHOENIXVILLE, PA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Nouriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GARDENS 7/23/98 FALLS CHURCH, VA 21. Signature of Funeral Service Licensee 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner sician and bunal-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last physician s tha burial P.O. Box 68760, Physician/Medical Due to (or es a consequence of) 88 use ŏ 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the page 2 should be datached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was en eutopsy Completed performed' 1 Yes 2 No 1 TYes 2 TNo cartificate or Attending Physician: director, 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28c. tnjury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.
To the Funeral Director: Al investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospitai 29a. Certifier 1 Contifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicat Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and magner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 20379 who completed ca ause of death (Item 23a) (Type, Print) Old Court Road, Balting Way 30. Neme and eddress of perso 11191 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature uistrar's Signature Randall State JUL 281998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month **Physician** JANET STAEHELI July 5 1998 6:20pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner ESSEX

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Dey, Year)
April 10,1930 163 Hampshire Road Baltimore If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) **Funeral** Months Deys 1 □ M 2X F Director 217-26-5061 68 MAryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalih and Martal Hygiene. Imprortant: If item 27 is merked other than "natural", or items 23e or 28e-1 show any injury or other thaumstic event, I'm Marical Expansion must be notified at any injury or other traumstic event, I'm Marical Expansion must be notified at 10d. Inside City Limits Md. Baltimore Essex Director 1 ☐ Yes X□ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 163 Hampshire Road 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bieck, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Detes: 1 ☐ Never Merried 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th Clerical 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Raymond Ward Mildred duFrainoi 2 19a. Informent's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Julius Staeheli /husband 163 Hampshire Road Baltimore MD. 21221 20b. Piece of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Locetion - City or Town, Stete Dete 1 € Burial 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Louden Park Cemetery 7/29/98 Baltimore MD. 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Connelly Funeral Home of Essex plications thet caused the deeth. Do not enter the mode of Sying, such as cardiac or respiratory errest; 21221 23a. Pert1. Enter the diseese, or con shock, or heert failure. List only Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical LARGE CELL LUNG CANGER Examiner Due to (or es e consequenca of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequenca of) P.O. Box 68760, Physician/Medical thet initieted events resulting in death) Lest phys Due to (or es e consequenca of) signed by the attending d be detached for use a Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records. þ 24b. Were eutopsy findings evelleble prior to 24a. Wes en eutopsy performed? page 2 should Completed peen completion of cause of deeth? this cartificate has 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 1 Yes 2/2 No 1 Inpatient 2 ER/Outpetient 3 DOA 5 Residence 6 Other (Specify) funaral 27. Manner of Beeth 28d. Describe how Injury occurred 28e. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? Aftar Attending 1 A Naturel 5 Pending investigation To the Hospital or Attendin within 24 hours aftar daath. To the Funeral Director: Af 1 Yes 2 No filled in by tha 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a, Certifier Medical Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted. completely Wedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

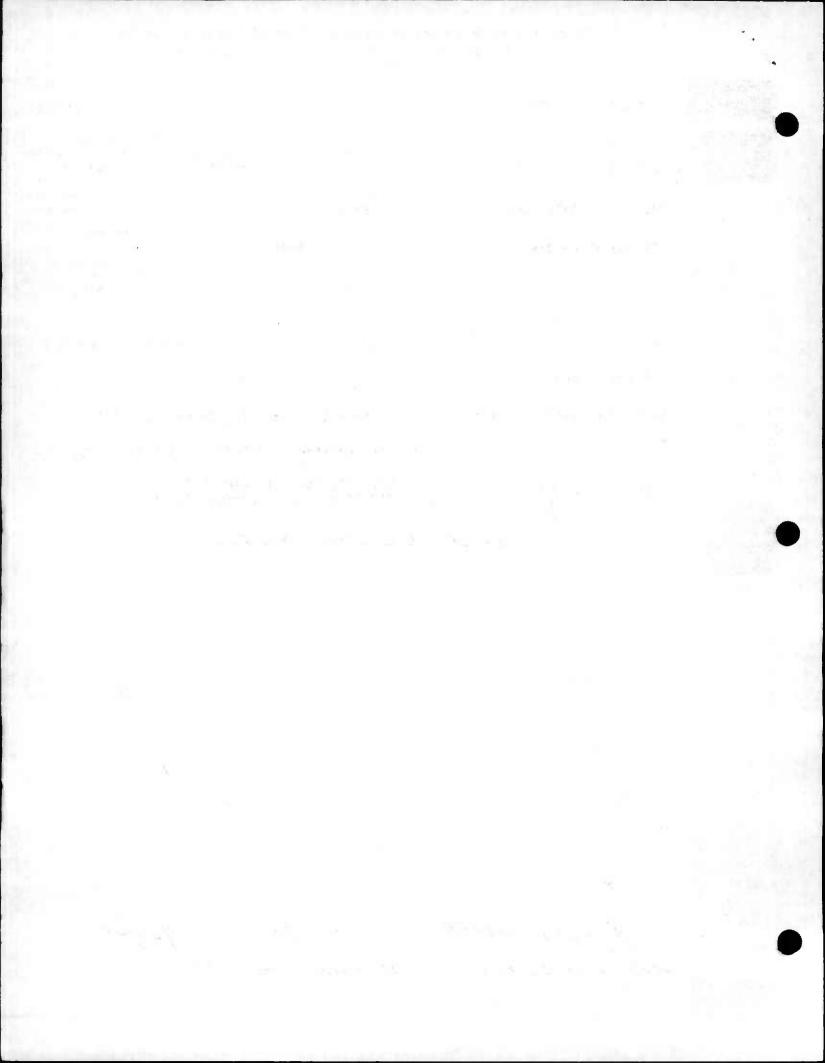
WHITE B2 Registrar's Signature Whe Davidson—Pandelle

1998

adse of deeth (Item 23e) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)



Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 1998 July 26 6:15 AM Joseph C. Staniewski, Sr. 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Manor Care- 6600 Ridge Road 21237 Rosedale | Hours | Min. | 8. Dete of Birth | Nov 24 1912 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) M d Months Deys 18 M 2□ F 85 Yrs. 214-01-9984 Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1'☑ Yes 2 ☐ No NA Baltimore, Md. 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21206 USA 4309 Willshire Avenue Was Decedent of Hispenic Origin? (Specity Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marilel Status Bleck, White, etc. 1 ☐ Yes 2 → No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 HNo Specify: Specify: White 3 ₩Widowed 4 Divorced Year or Deles 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Chauffeur 3rd Beer Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Michael Staniewski Mary Anna Unknown 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Joseph C.Staniewski/son 3014 Linwood Ave. Baltimore, Md. 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State St. Stanislaus Cemetery 7/29 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Hartley Miller Funeral Home, CHTD. 7527 Harford Rd. Baltimore, Md. 21234 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Pulmonony Mulhple 4 wk Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thei initiated events Due to (or es e consequence of): Due to (or as e consequence of): resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? heart failure, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24e. Was en eutopsy 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23a or the Medical Examiner must be

if it is a filed within 72 hours after if Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th eny lojury or other traumatic event, the once.

altimore, Maryland 21215-0020

the Maryland r 28a-f show

Physician/Medical Examiner ed by the attending posterior detached for use as signed to à peen

page 2 has certificate director. this funeral

Completed Be 25. Wes cese referred to medical examiner? 2

Certification:

edical

To the Hosp within 24 hox To the Fune completely fi

Records, P.O. Box 68760, Division of Vital Hospital or Attending Pl 124 hours after death.
 Funeral Director: After the bletely filled in by the funeral

> 0 State

> > Registrar

31. Dete filed (Month, Day, Year) JUL 271998

29b. Signature end title of certifier

1 Yes 2 No

27. Menney of Deeth

1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a Certifier

38. Registrar's Signeture www. Davidson-Randell

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

Hospital:

5 Pending investigation

6 Could not be

28e. Dete of Injury (Month, Dey Yeer)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D - 38 754 . 29d. Dale signed (Month, Dey, Year, D - 27 - 98 29d. Dale signed (Month, Dey, Year)

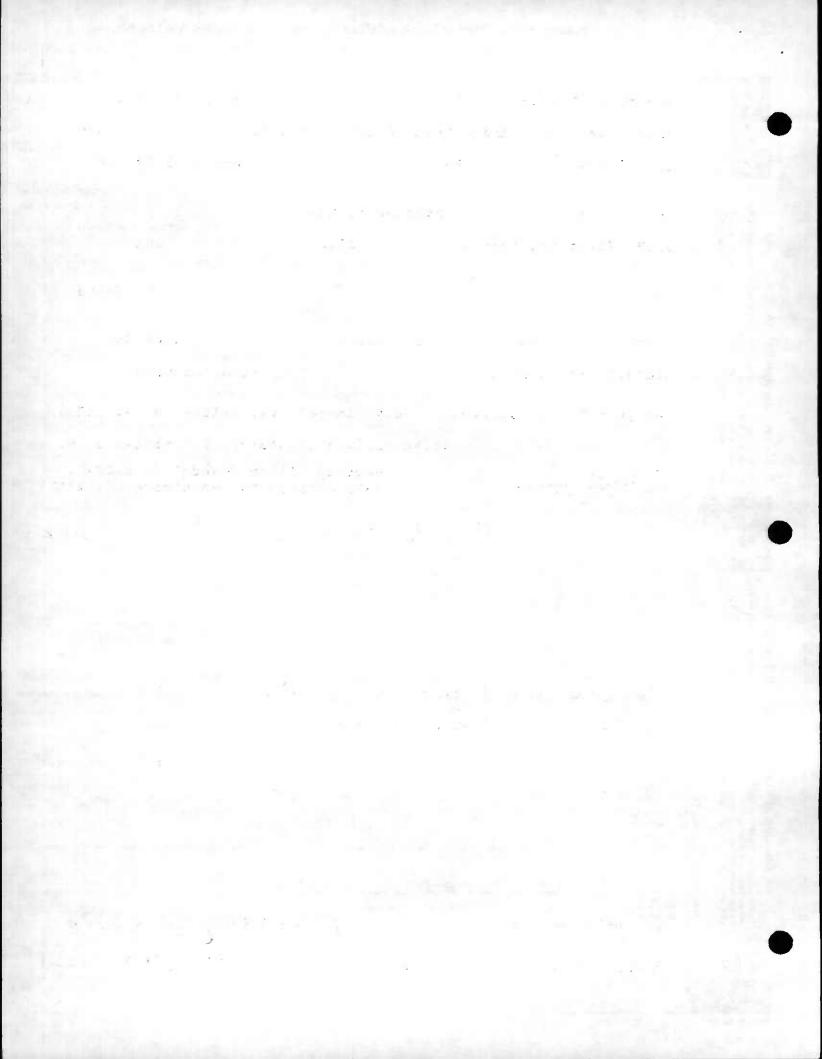
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describa how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

26. Plece of Deeth (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTERN BLVD. MD-21221



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month Veer **Physician** 22, 1950 h 4c. County of Death Salvatore Anthony Tumminello, M.D. 4b. City, Town, or Location of Deeth 6:10 PM /Medical 4e Fecility Neme (If not institution, giva street and number) Examiner 49 Acorn Circle Apt.202 Towson Baltimore Co. If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Funeral Deys 112 M 2 F Vre Director 224-60-1905 94 Dec. 26, 1903 Baltimore, Md. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e Stete show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified all once. 1 Tyes 2 No Maryland Baltimore Co. Towson Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 49 Acorn Circle Apt. 202 21286 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Yaer or Dates: Race - Amarican Indien, Black, White, etc. Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married Married 1 Yes 27 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 08 Physician HealthCare 18. Mother's Neme (First, Middle, Malden Sumama) 17. Fether's Neme (First, Middle, Last) Be Vincent Tumminello 2 Mary Cascio 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Retetionship (Type, Print) Mrs. Mary Ann DeGele (Daughter) 3111 Wellington Way Baldwin, Maryland 21013 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Nother (Specify) Entombrent Dulaney Valley Mem. Gard. 7/25/98 Timonium, Maryland 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 21, Signatura of Funaral Sarvice Licent 1050 York Road Towson, Md. 21204 23a. Pert1. Enter the disease, or a m shock, or heart failure. Ust only a implications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical APULINSON'S DISKMER Vors Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immadiete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Yo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy his certificate has be director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case rafarrad to medical Be 26. Pieca of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes ≥ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this funeral 27, Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of Attending 5 Pending investigation Naturel 124 hours after death.

• Funers! Director: A bletely filled in by the fr death. 1 Tyes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Hospital or Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier edicai 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 29c. Licansa number 28811

YORK RD STE 102, TOWSON, MD

State Registrar 31. Dete filed (Month, Dey, Year)

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30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

281998

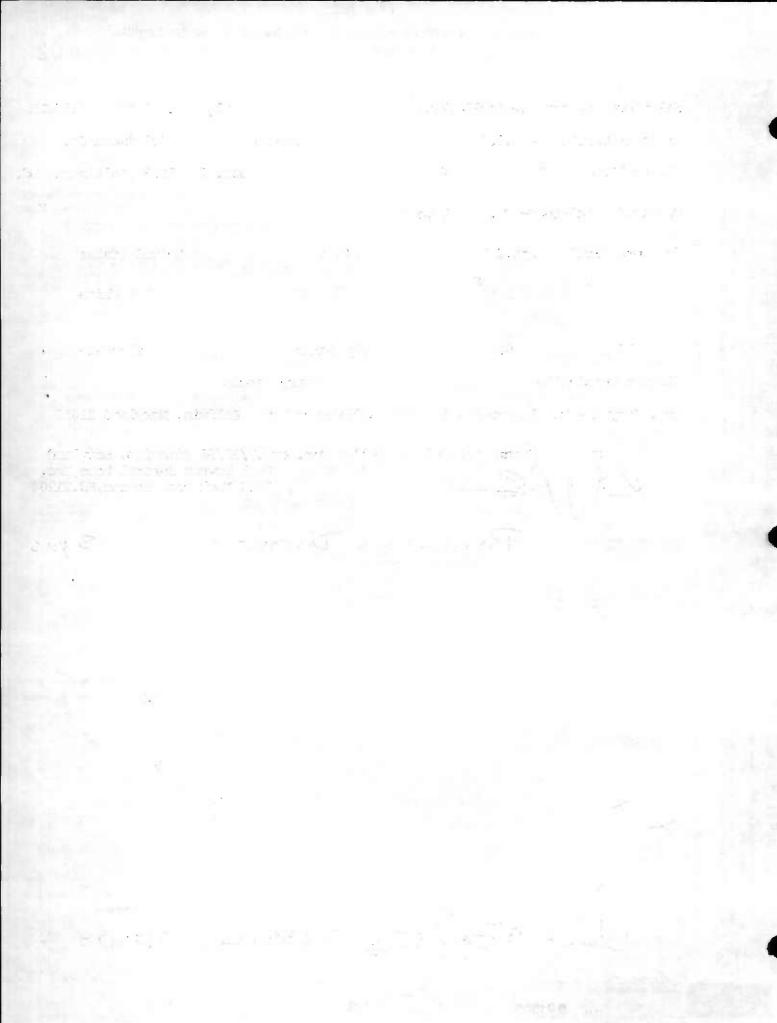
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32. Registrar's Signeture

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O. Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#1 perPhy G762 8/4/98 EW Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** TURNER SR MARIS GORDON 1998 JUL 23. /Medical unknown 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner JOPPA 615 DEMBYTOWN ROAD HARFORD If Under 1 Year Months Days If Under 24 Hrs. Birthplece (Stete or Foreign Country)
 MARYLAND 8. Dete of Birth (Month, Dey, Year) APR 29 1924 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X X 2 F 74 Director 216-16-9929 Usuel Residence of Decedent the Maryland 10e. State 10c. City, Town or Location 10d. inside City Limits 10b. County ehow. itam 27 is marked other than "natural", or items 23a or 28a-f shoothar traumatic event, the Medical Examinar mast be notified at 1 Yes 2XXVo Directo **JOPPA** MARYLAND HARFORD 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 615 DEMBYTOWN ROAD 21085 U.S.A. death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decadent Ever in U,S. Armed Forces? 11. Maritel Status pemit. Pagas 1 and 2 should be filed within 72 hours aftar 1 Department of Health and Manial Hygiene. Important: If itsm 27 is marked other than "natural", or iter any injury or other traumetic event, the Medical Examples 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No 43/46 Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CONSTRUCTION MAINT FOREMAN DEPT OF DEFENSE 12th grade 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be EDITH PETERS HENRY ALBERT 2 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Keith J. Turner/Son 605 Sugarhill Rd, Joppa, Maryland 21085 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Durial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 7-28-98 MIDDLE RIVER, MARYLAND HOLLY HILL MEMORIAL 21. Signature of Funeral Service Licanses 22. Name end Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel BRONCHOGENIC CANCER disease or condition resulting in death) Examiner Examiner bung-Iransit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequenca of) signed by the all d be datached to 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy peen completion of cause of deeth? 1 Yes 2 100 1 Yes 2 No or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation ne Hospital or Attending in 24 hours aftar death. The Funeral Director: After plately filled in by the fun 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical complately 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. within 2 To the F 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 29c. License number

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State 31. D

31. Date filed (Month, Dey, Yeer)

JUL 281998

ROKER X 32. Registrer's Signeture Guno Davidson-Gandare Juns

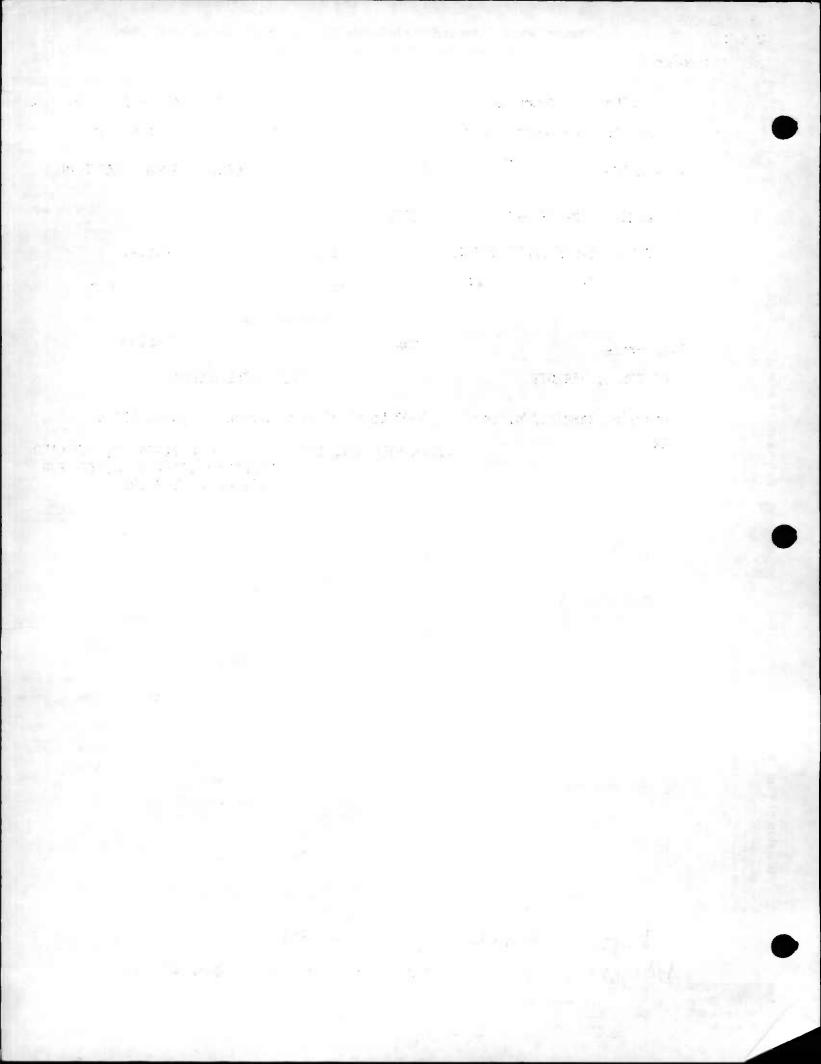
30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

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	Examir	ner	4a Facility Name (If not institu 3 TIMBER CRE					wn, or Loc SEX	ation of Death	-	of Death					
	Funeral Director		5. Social Security Number 220-68-7034	6. 9	Sex 7 I□M 2KDX 7	. Age (In yrs.	18st birth	Month	der 1 Year ns Days	If Under Hours	Min.	8. Date of Birth (Month, Day, DEC. 5	Year) 1960	Coun	lace (Stata or try) YLAND	Foraign
	lend ww		Usual Residence of Decedent 10a. State 10b. Cour	ity		10c. Ci	ity, Town	or Location						1	0d. Inside Cit	y Limits
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	s 23a		3 TIMBER CRE					212	221 Hispanic Origin? (Specify Yes or No-			U.S.A		on Indian		
15-0020 n 72 hours after death with the Meryland *natural; or items 23s or 28s-f show sideal Examiner must be notified at leted by Funeral Director	by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ Wolld H Yes, Give Year or Dates:		es? XXVo	If Yes, spe		specify Cuban, Mexican, Puerto Ri			Rican, etc.) Bi		e - American Indian, ck, White, etc. y: BLACK				
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Page ment or ury or		20a. Method of Disposition XIX Burial 2 ☐ Crematic			Place of Disposition (Nama of comatery, crematory or other place DAR HILL CEMETE					Date 20c. Location - City 7-27-98 BALTIMORE						
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n	Ing PI		27. Manner of Death 1 X Natural 5 □ Pen			Injury Day Year)	28b. Tir Inj	ury	28c. Inju Wo			28d. Describe ho	w Injury occur	red		
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<u>≥</u>	effer Direction by	Certification:	4 ☐ Homicide dete	rmined	building	g, etc. (Speci	lfy)	n, 311061, 140	tory, omce		-	City or Town		707 07 7 1010		507,
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	1. De	cedent's Nam	ne (First, Middle	e, Last)	4							2. Data of De			3. Time of Death
nysician	Donald Eugene Thomas						July	22, 19	Year 98	10:00ar					
Medical xaminer	4a F									inty of Deeth					
Examiner		3029	Hunti	ngdon	Aven	ue				Ba	ltimo	re		N/A	
Funeral		cial Security N	-	6. Sex	7.	Age (In yrs	. last birt		r 1 Year	If Under		8. Dete of Bi	th Year)		nplece (Stete or Fore
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			rled XX Marri	led	Was Decede Armed Force 1 XYes 2 If Yas, Give Yeer or Date	es? □ No WW		13. Was Dece If Yes, spe		Specify:		Rican, etc.)		Bleck, White	, etc.
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	17. F	ether's Neme	(First, Middle, I	Last)						18. Moth	er's Name	(First, Middle	, Meiden Sun	neme)	
		Edward Thomas Ma						Ma	ry Stinchecomb						
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	Aı	nne L.	Thomas	(Wi	fe)			3029 Hur	nting	don	Avenu	e. Ral	timore	Mary	vland 212
	-	Method of Dis		(11.2		20b.	Place of	Disposition (Ne	me of	ool	Avend	Date	20c. Locati	on - City or	yland 212 Fown, State
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	238	Part Enter t	the disease, or	complicati	ions that sau	the dea	ath Dor								Approximate
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VANDYKE, BEATRICE

-	- 1	Decedent's Name (First, Middle, L	ant)		Cei	rtificate	of L)eath	0.5		, No.	C. 1/	100					
Physicia /Medic		Beatrice Marie Va	anDyke						J			Year 998 1	ime of Death					
Examin	er	4a. Facility Name (If not institution, g	ive street and nu	m <i>ber)</i>				b. City, Town		on of Death	4c. County	of Deeth						
		Stella Maris 5. Social Security Number 6.	Sex	7 Ann //n	In a t hinth day.	If Under 1		imoniu If Under 24		Date of Dist		imore C						
Funeral Director		214-24-6502	1□M 2XF	7. Age (iii yis.	last birthday) Yrs.		Days		Min. (Date of Birth Month, Day, Y			State or Foreign					
		Usual Residence of Decedent)				TVC	ov.02,	1927	ватсшк	ore, Md.					
a or 28a-f show be notified at	ctor	Maryland Baltim	ore Co.		ity, Town or Lo Ockeysv								side City Limits Yes 2500					
9 2 S	Director	10e. Street and Number				10f. Zip C	ode			100	g. Citizen of V	What Country?						
23a	ral	321 Lake Vista C	ircle			21	.030			J	mited	States						
Items in items	Funeral	11. Marital Status	Armed Fo		J,S. 13. 1	Was Deceder If Yes, specify	nt of His Cubar	spanic Origin n, Mexicen, F	? (Specify Puerto Rice	Yes or No- n, etc.)		e - American Inck, White, etc.	dian,					
0 11 1		1X Never Married 2 Married 3 Widowed 4 Divorced	1 Tes	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ 1			ON D	Specify:			Specify	<i>y</i> :						
E E	15. Decedent		Year or D	ecedent's Usual Occupation				146	Sh. Kind of D.	White								
Andica	oleti	(Specify only highest g	rade completed)		(Give	kind of work	done di	uring most of	f working	16	bb. Kind of Bi	Business/Industry						
Te a	(Specify on Elementary/Secondary		College (1-4or 5+)		ecutiv			277.7		MaCox	nials Co	ico					
17. Father's Name (First	17. Father's Name (First, Middle, Las			120	ecuciv				st, Middle, Ma		nick Sp:	rce						
Mental Hygiene. srked other than "natural", or items 23a or 28a-f show atto event, the Medical Examiner must be notified at TO Be Completed by Funeral Director		Wilson James VanI)vke					Hilda	Elear	nor Sch	lenne	3						
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; any injury or other traumatic evant, it a Medical Exagnice. To Be Completed by	19a. Informant's Name/Relationship	-		19b. Mailir	ng Address (S						State, Zip Code)						
	Thomas A. Bennett	(Brothe	r In La	aw) 30	Belmor	e R	oad I	Luther	ville,	Md.	21093							
	20a. Method of Disposition		20b. Place of Disposition (Name of Date 20c. Location - City								City or Town, S							
	1 DBurial 2 □ Cremation 3 l 4 □ Donation 5 □ Other (Spec		Removal from State									land						
any inju		21. Signature of Funeral Service Lice	nsee Jeffr		air 22	2. Name end	Address	s of Facility	Ruck	rowson	Funera	al Home	. Tnc					
E & 8		Jypen 7		in								son, Md						
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that of	eaused the deal	th. Do not ent	er the mode of	of dying	, such as ce	rdiac or res	piratory arres	t,	Inter	oximate vei Between					
sician edical		Immediate Cause (Final										Onse	et and Death					
niner		disease or condition resulting in death)	a	PNEUMO	NIA													
	ē			Due to (or as a consec	quence of):												
Ž	Examiner		b			1.0												
tal-tra	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury		Due to (or as e conseq	luence of):						į						
20	edical	triat irritiated events	C	Due to /e		uonee of).								_				
(0)	800	resulting in death) Last		Due to (or as a consequence of):								1						
	2		d									1						
of fo	sick	Part II. Other significant conditions	contributing to de	eath but not res	sulting In the u	nderlying caus	se aive	n in Part I.		23b. Did tob	acco use cor	ntribute to the	auae of death?					
The law requires that the death centrate has been signed by the ettendin page 2 should be detached for use Completed by Physician/N	h.									23b. Did tobacco use contribute to the cause of								
	No. of the Control of											N-M						
										24a. Was an		24b. Were eu eveilable	topsy findings					
0	The lew requir									periorne	ed r	completi of death	on of ceuse					
2 sho										1□ Yes	2 K No	1 ☐ Yes	2□ No					
oage 2 sho	E O																	
tor, page 2 sho		25. Was cese referred to medical			examiner? Hospital:						26. Plece of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
director, page 2 sho	Be		Hospitai:	Inpatient 2	ER/Outpatien	it 3□ DOA	Other	r: 4 Nursi	na Home	5 ☐ Residence	ce 6 Oth	er (Specify)						
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State Registrar 31. Date filed (Month, Day, Year)



2300 Dulaney Valley Rd

Timonium, Md

21093

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

Ebrahim Ipakchi, M.D.

88 35-F DJA 70-6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month July **Physician** 3:06 am Fitz Vest /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1**▼**M 2□F Director 223-09-2809 Nov 29, 1912 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Directo Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? mant be n 115 Hollow Brook Road 21093 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. arked other than "natural", or iter atic event, the Medical Exempler 1 ☐ Yes 2 XNo If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: ğ 3 ¥Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filled within and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Industrial Manager Exxon Oil Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Fitz Lee Vest Annie Elizabeth 19a. tnforment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 224 Purlington Road, Timonium, Maryland 21093 Clifford A. Vest/Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete tment of 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 7/29/98 Richmond, Virginia 4 Demation 5 Other (Specify) Forest Lawn Cemetery 22. Name and Address of Fecility of Funeral Service Licens Lemmon Funeral Home 10 W. Padonia road, Timonium, MD 21093 ed the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, line. Approximete intervet Between Onset and Deeth liseese, or complications that cau-**Physician** Immediate (disease or condition resulting in death) /Medical 7dass Aspiration Preumania Examiner Due to (or es e consequenca of): Physician/Medical Examiner 10 days Hemorraghic Stroke Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Couse (Disease or injury that in the desertions) Due to (or es e consequenca of): P.O. Box 68760, The law requires that the death certificate be thet initiated events resulting in deeth) Lest Due to (or es e consequença of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Colon cancer - metastatic to lung signed d be del Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? is certificate has I director, page 2 s 1 Yes 2 No 1 Yes 2 No al or Attending Physicien: The safter death.

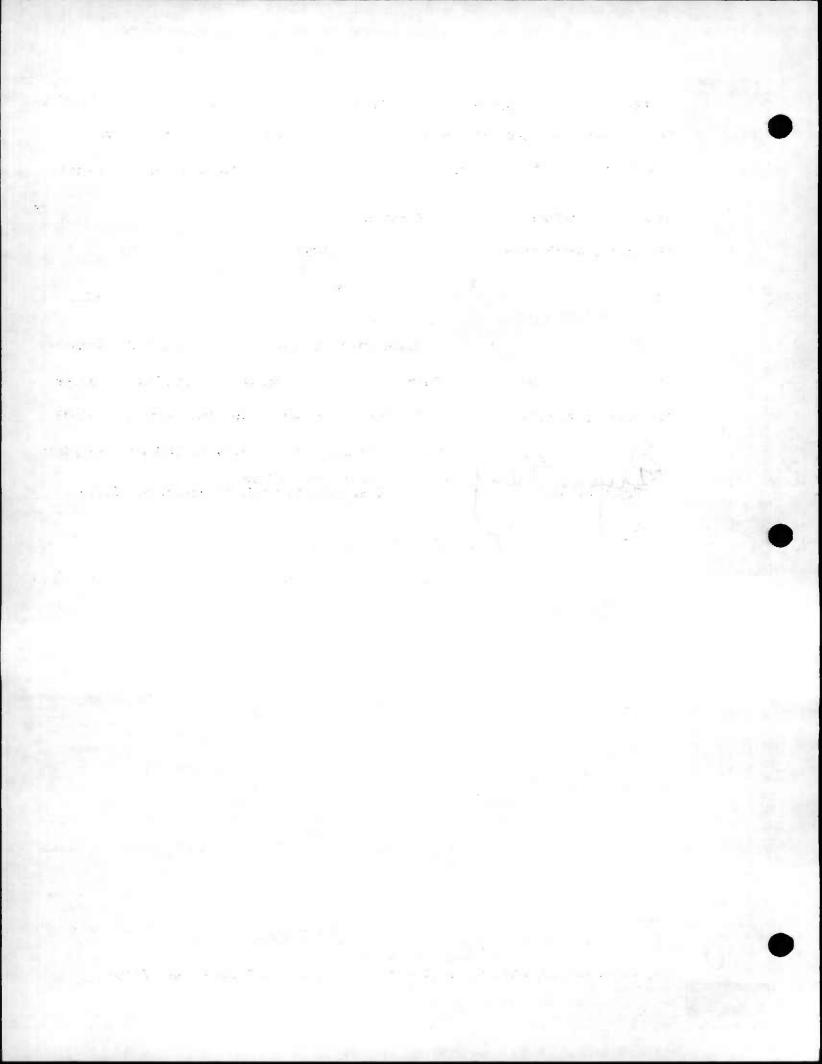
I Director: After this certificated in by the funeral director, pa Be 25. Was case referred to medicaf 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury et Work? 28e. Dete of fnjury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner as steled.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical 29b. Signature and life of certifier 29c. License number 29d. Date signed (Month, Pay, Year) D43489 1/80hm 30. Name end eddress of person who completed cause of death (ttem 23e) (Type, Print) Dr. Brian Bohnen, 6569 N. Charles St., suite 407, Baltimroe, MD JUL 281998 Registrer's signatur Davidson Pandall 31. Dete filed (Month, Day, State

DHMH 16 Rev 6/95

Registrar

Agnew Ves



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item#10f,19b per Inf G761 7/29/9 State of Maryland / Department of Health and Mental Hygiene Items: 23 part I,26 per M.D G-761 7/28/98 rebCertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Harry Herbert Wanner, Jr. JULY 9, 1998 19:30 /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death SAINT AGNES HOSPITAL, 900 CATON AVENUE BALTIMORE Baltimore City 7. Age (In yrs. last birthdey) If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Hours 82 170-07-3952 March 24, 1916 Pennsylvania Director Usual Residence of Decedant the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Baltimore County Baltimore Maryland Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21229 21227 U.S.A. 921 Elm Ridge Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 M Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry el Hygiene. Elamentary/Secondery (0-12) Collega (1-4or 5+) 12 Contract Negotiator Defense 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Peges 1 end 2 should be file ment of Health end Mentel Hy ant: If Item 27 is marked oth ury or other traumatic even Be Harry Herbert Wanner Mary Amanda Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Stata, Zip Code) Mary L. Wanner/wife 921Elm Ridge Avenue, Baltimore, Maryland 21227 21229 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or 4 ☑ Donation 5 ☐ Other (Specify) 21. Signalum of Fundral Service License 22. Neme end Address of Facility Director Ronald S Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, slock, or heart failure. List only one cause on each line. Approximate Intervel Betwaan Onsat and Death **Physician** Imm - fiate Cause (Finel disease or condition resulting in death) /Medical Ruptured abdomeral Rortic anewym 30 MIN **Examiner** ABDOMENAL AORTIC ANEURYSM siclan and bunel-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lest Due to (or as e consequence of) Physician/Medical the Due to (or as e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuss given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Wara autopsy findings eveileble prior to completion of ceuse of daath? Completed 24a. Was en autopsy performed? certificate has 1 Yes 2€No 1 ☐ Yes 2 ☐ No Be 25. Was case refarrad to medical 26. Piece of Daeth (Check only one) Other: 4 Nursing Home + Sections 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 2 DOA 1 Yas 28 No Certification: To this 28c. Injury at Work? 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred After t 5 Panding invastigation 1-Selatural deeth. 1 ☐ Yes 2 ☐ No 2 Accidant efter deeth 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) P 4 Homicida →To the Hospital o within 24 hours of To the Funeral Di completely filled in 12 Sertifying Phyalcian: To the best of my knowladga, daath occurred et tha tima, data and place, end due to tha causa(s) and manner as stated.

2 Medical Exeminer: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29a. Certifian (Check only

P.O.

Records,

Vital

of

Division

HERRER

State Registrar 29b. Signature end title of certifian

CUMLES CUETIS 32. Maintrary signature 31. Date filed (Month, Day, Yeer) 281998

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30. Nama and address of person who completed causa of daath (Item 23e) (Type, Print)

MUSPITHE, BALTIMONE, MD

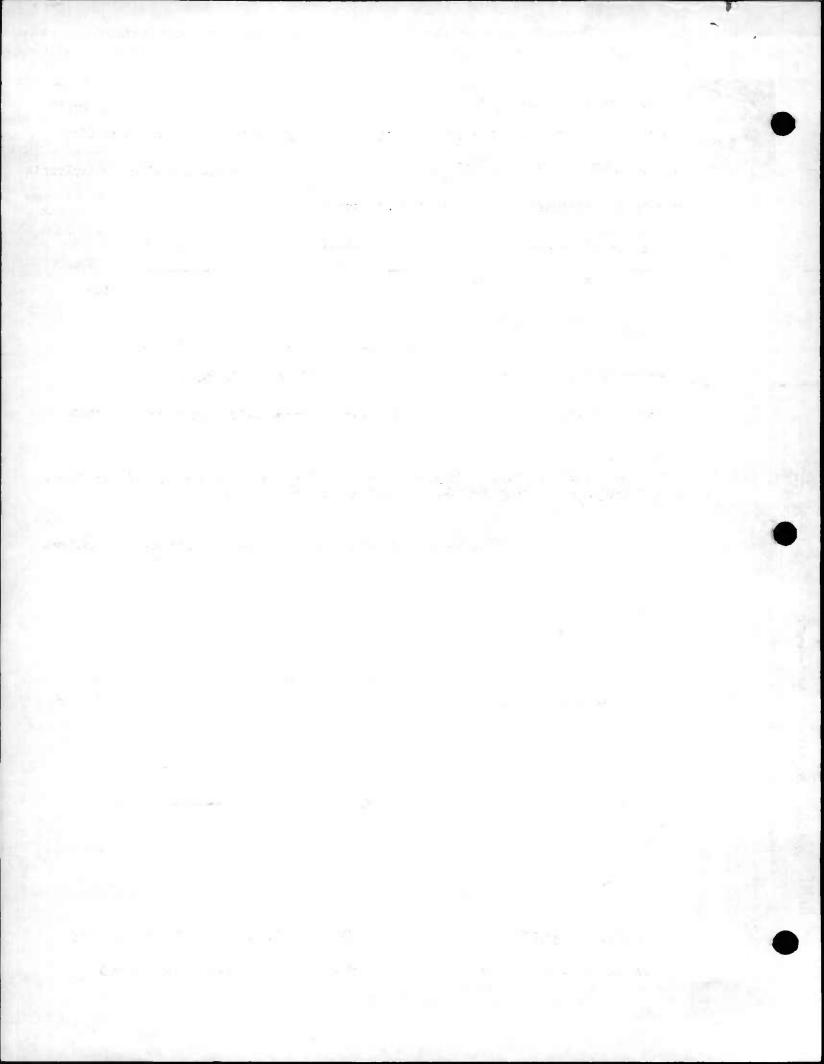
AGNES

29c. License number

D0051865

29d. Date signed (Month, Day, Year)

JULY 9, 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year July 98 Williams 23, 13:40 Maxine 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 2804 Maisel Street Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Months Days Hours 1 M 2X F 38 07-24-59 MD 219-80-6369 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2 □ No Md Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2804 Maisel Street 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Never Married 2☐ Married 1 ☐ Yes ♣ No If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Janitorial Services 12th Grade 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) т. Williams Thessoline Massey James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 19a. Informant's Name/Relationship (Type, Print) 2804 Maisel Street Baltimore, Maryland Thessoline Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 07-29-98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Baltimore, of Funeral Service License Maryland 21202 Wm. C. March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final BREAST CANCER disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 2000 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 2 X No Residence 6 □Other (Specify) 1 ☐ Yes 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury et Work? 28b. Time of 1 MNatural 5 Pending Injury

Physician /Medical Examiner

iny injury or

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at

I Hygiene.

Department of Heelth and Mental Hygismoortant: if Item 27 Is marked other

death with the Marylend

Pages 1 and 2 should be filed within 72 hours efter

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altimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

Physician/Medical by Completed Be 2 Certification:

Examiner

or Attending Physician: death. 24 hours after deat Funeral Director; filled in by Hospital within 2 To the

edical completely

29a. Certifier (Check only one) 29b. Signeture and title of certifier

&□ Accident

3 Sulcide

4 ☐ Homloide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

KATHERINE , UNW. OF MD CANCER CIR, 225 Greene St, Baltimore 21701 KACTUK 31 Date filed (Month; Day, Year)

Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es steted.

State Registrar

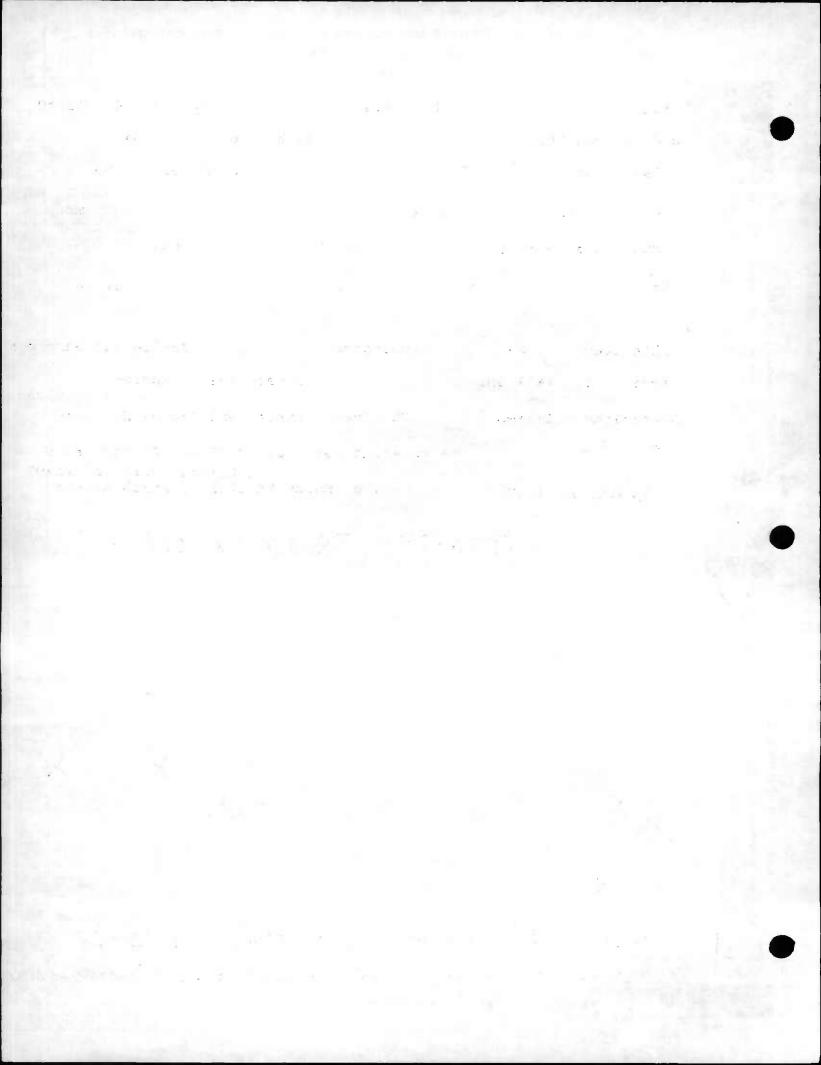
281998

Investigation

6 Could not be determined

32. Degistrar's Signature

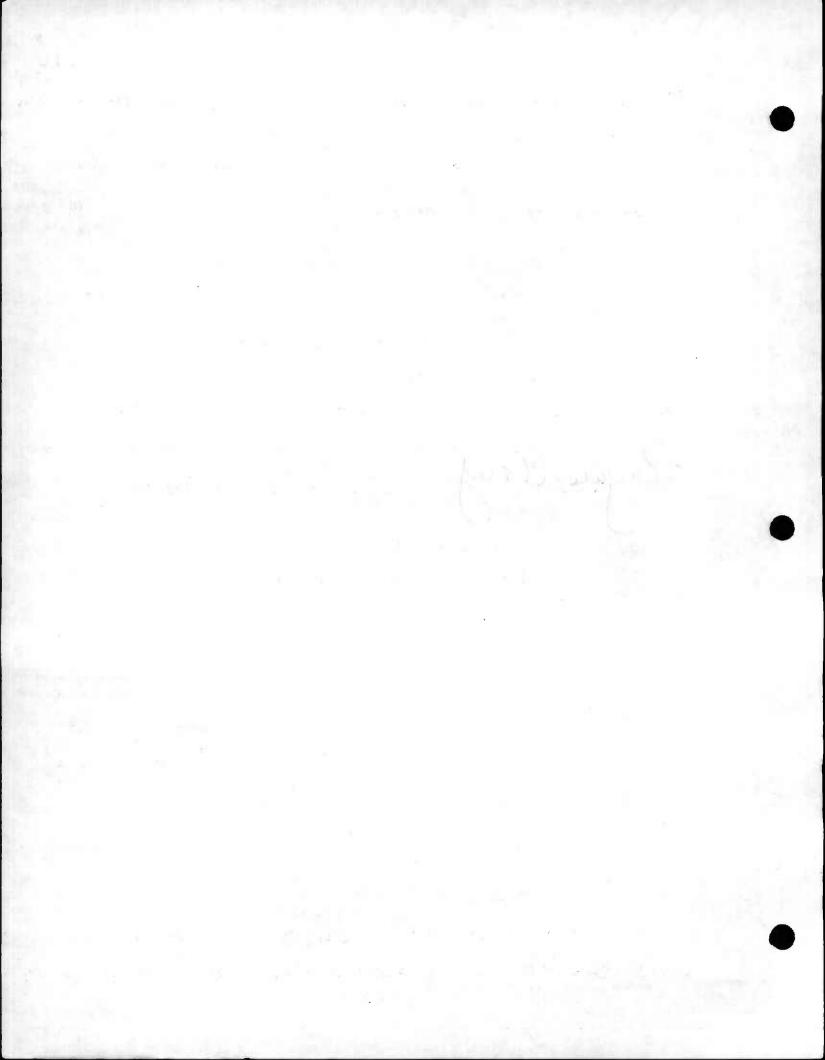
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** STEVEN HIDREW WRABEL 1998 6:35 AM 25 Juli /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Joseph's Medical Center Baltimore Towson If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) March 2,1920 9. Birthplece (State or Foreign 5. Social Security Number If Under 24 Hrs. **Funeral** Months Days Hours 1 M 2□ F Vrs 78 Ohio Director 294-07-5752 **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2 No Director Maryland "natural", or items 23a or 28a-f Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21093 IISA 123 Tregarone Road 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry ntal Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 03 12 Railroad Chief of the Invoice Bureau pemit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumetic events 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Wrabel Kopchak Peter Anna A. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Tregarone Road, Timonium, MD 21093 Loris Mildred Wrabel/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Depetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns 7/29/98 Timonium, Maryland 21. Sign 22. Name end Address of Fecilit Bryan W. Clary Lemmon Funeral Home 21093 10 W. Padonia Road, Timonium, MD 23a. Part1. Errer the disease, or complications that caused the shock, or heart sulture. List only one cause on each line Approximete interval Between Onset end Death deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) KENAL FAILURE Examiner Due to (or as e consequence of): Examiner ORONARY ARTERY DISEASE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760. The law requires that the death certificant be Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 X No certificate Division of Vital Mospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifical eleiely filled in by the funeral director; p. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 112 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 28 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check only one) 29b. Signature end titte of celtifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) ATHISM. DGIN M.D. 7620 YORK ROAD TOUSON MARYLAND 21204 31. Date filed (Month, Dey, Year) 281998 32. Registres Signetus Jundson Randall State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JEAN SMITH WALLER 1998 2:40 PM 25, JULY 4b. City, Town, or Location of Desth 4c. County of Death 4a Facility Name (If not institution, give street end number) ROLAND PARK PLACE BALTIMORE N/A If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Days 1 M XX 212-50-3994 82 Yrs 08-01-1915 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD. N/A BALTIMORE CITY XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 WEST 40th. STREET 21211 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, Whita, atc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: WHITE XX Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION TEACHER YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) HOWARD MARION BELL FRANKLIN SMITH 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JEAN W. BRUNE (DAUGHTER) 3 DEEPDENE ROAD, BALTIMORE, MARYLAND, 21210 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, Stata XX Burial 2 Cremation 3 Removal from State DRUID RIDGE CEMETERY 7-29 PIKESVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility HENRY W. JENKINS AND SONS COMPANY 21. Signature of Funaral Sarvice Licanses 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 alles) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SPIRATION Due to for es a consequent Due to (or es e consequence of) menlia Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes XXNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa XX Residence 6 Other (Specify) 1 Yes XX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral, or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If Item 27 ie merked other than "natural", or Items 23a ente, Injury or other traumatic event, the Medical Examiner Invest and Dece.

Baltimore, Maryland 21215-0020

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Funeral

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signed by the e peeu page 2 Physician/Medical Examiner

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Completed

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Certification: To

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X Natural

29a. Certifier

2 Accident

3 Suicida

4 Homicide

The law requires that the death certificate certificete Hospital or Attending Physician: director, this After this deeth. ofter deeth.

Director: A
d in by the f To the Hospital or within 24 hours eft To the Funerel Di completely filled in

Division of Vital Records, P.O. Box 68760,

State

Registrar

29b. Signature and blood certifier

5 Pending Investigation

6 Could not be determined

29c. Licensa number 206 49

1 ☐ Yes

XX Certifying Phyaician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s)

2 No

29d. Date signad (Month, Dey, Year) 8

Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

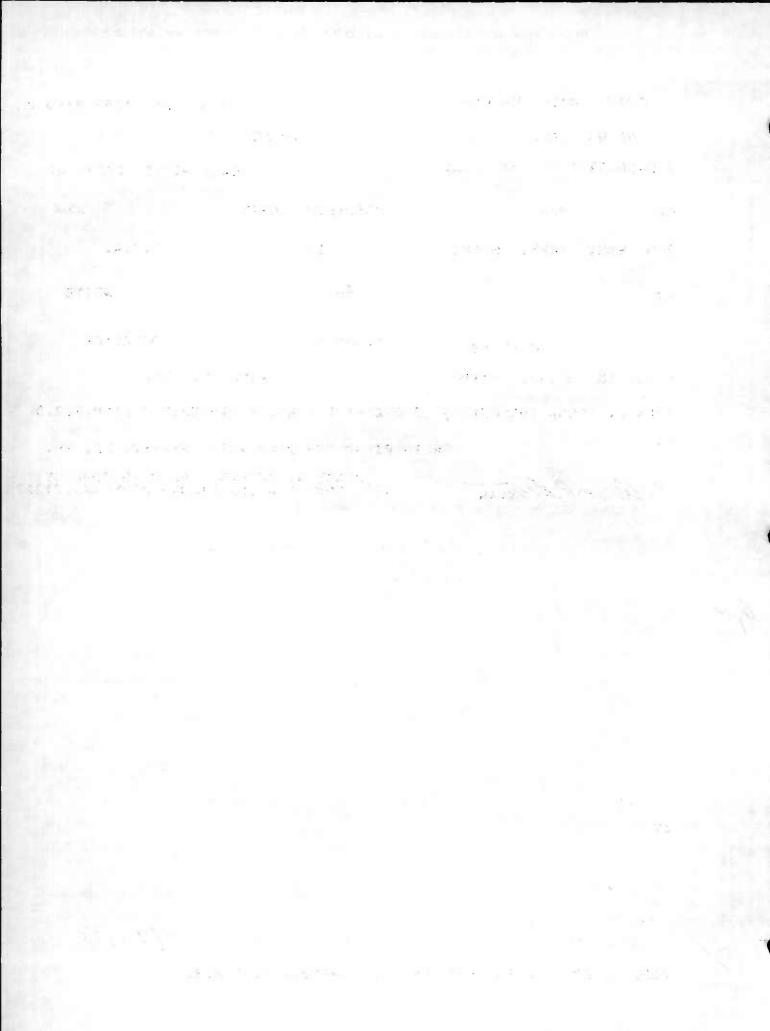
and manner stated.

BOWIE M.D. 6800 YORK RD. BALTO., MD. 21212.

28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)

81998

32. Registra's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth July Yeer **Physician** Donald 7:42 1. 10,1+ 24 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balt: more Johns Hopkins Bayview Medical If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpleca (Steta or Foreign Country) **Funeral** Months Devs Min. *□M 2□F Hours 283-24-0672 70 Yrs. Director Oct. 28, 1927 Ohio Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryla Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be recited as once. Maryland Director 1 ☐ Yes 2 ☐ No Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? 117 Briarwood Road 21222 United States Funeral 12. Wes Decadent Ever in U,S Armed Forces? 13. Wes Decadent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1946-47 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ XXWidowed 4 □ Divorced Specify: White Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Unknown Disabled 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Harvey J. Wilt Amellia Johnson 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Eva Lanier (Sister-in-law) 814 Wise Avenue Baltimore, Maryland 21222 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 7/28/98 Glen Burnie, Md. 21. Signature of Funerel Servica Licansea 22. Nama and Addrass of Facility Y Bish Duda-Ruck Funeral Home of Dundalk, Inc. 19 houses Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, approximate interval Beh 23a. Part1 **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Infarction · Acute Examiner 13 hours Due to (or es e consequence of): Examiner Anteny Coronary Disease 3 years Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or as e consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of) P P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2□ No 3 Probably 4 ☐ Unknown Records, þ 8 24b. Were eutopsy findings eveilebla prior to Completed 24e. Wes en eutopsy peen performed' completion of cause of deeth? paga 2 cartificata has Tha 1 Yas 2 No 1 ☐ Yes 2 ☐ No. Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completally filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) Hospital: 1⊠Inpatient 2□ ER/Outpatient 3□ DOA 2 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Straat end Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

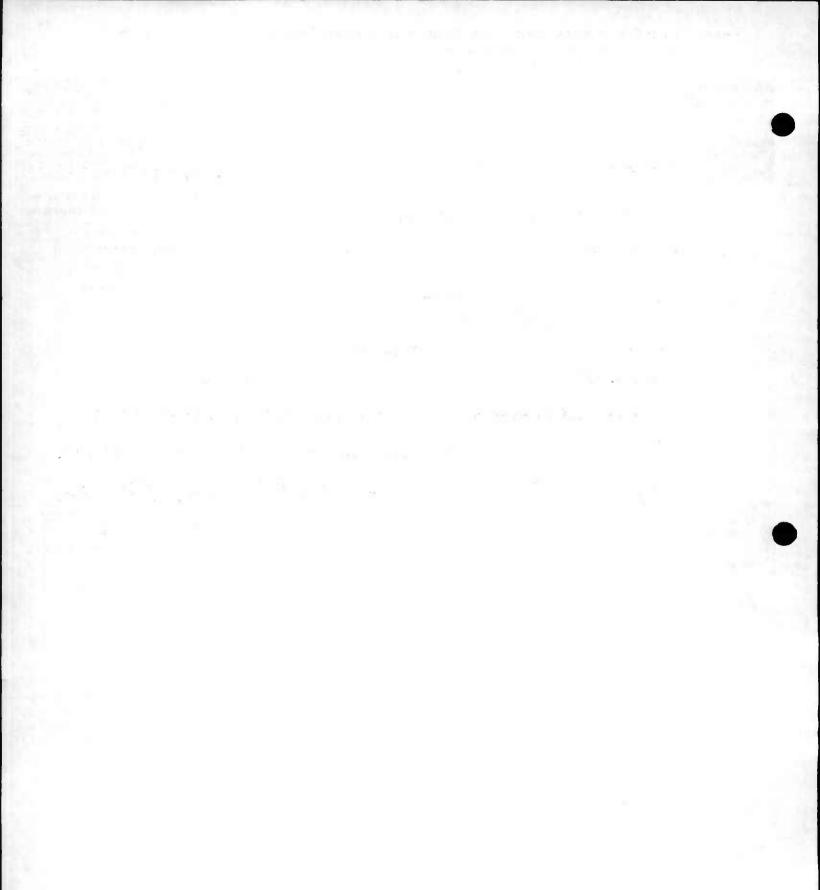
2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner steted. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) elle July WD AF 266 4200 - 305 24, 1998 Drogan Baltimore, MD 21224 30. Name end eddress of parson who completed cause of deeth (Item 23e) (Typa, Print) 4940 Eastern Avenue Grogan Bayvin Medical Center Johns Hopkins

32. Registra's Pignante. June Day doon - Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 20, 1998 9:50 AM EVELYN WEINER 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pey, Year) JULY4, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 M 2 KF SC Yrs. 79 239-03-9644 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 7915 CRISFORD PLACE #F 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) ANN KRAMER **GEORGE** UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Malting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD 21209 STEPHEN WEINER (SON) 6632 CHIPPEWA DRIVE 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL PARK 7/22/98 RREISTERSTOWN, MD 21. Signature of Faneral Servica Licenti 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD PIKESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lears TV C Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of). Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1 No 1 Yes 2 ₩o 1 ☐ Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Marital Pyglene.
Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Experimentments to notified an once.

Baltimore, Maryland 21215-0020

Box 68760

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burial-transit attending physician end for use as the burial-trar signed by the a Deen page 2 s director,

Physician/Medical Examiner þ Completed Be 2

The law requires that the death certificate be executed After this certificate hes i or Attending Physician: efter death. In by the funerei Director: within 24 hours a To the Funeral C Hospital

Certification:

Alan State Registrar

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25. Was case referred to medical examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatienf 3 DOA 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Neturel

28d. Describe how injury occurred 5 Pending investigation M 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) determined 4 Homicide

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2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of cartifier

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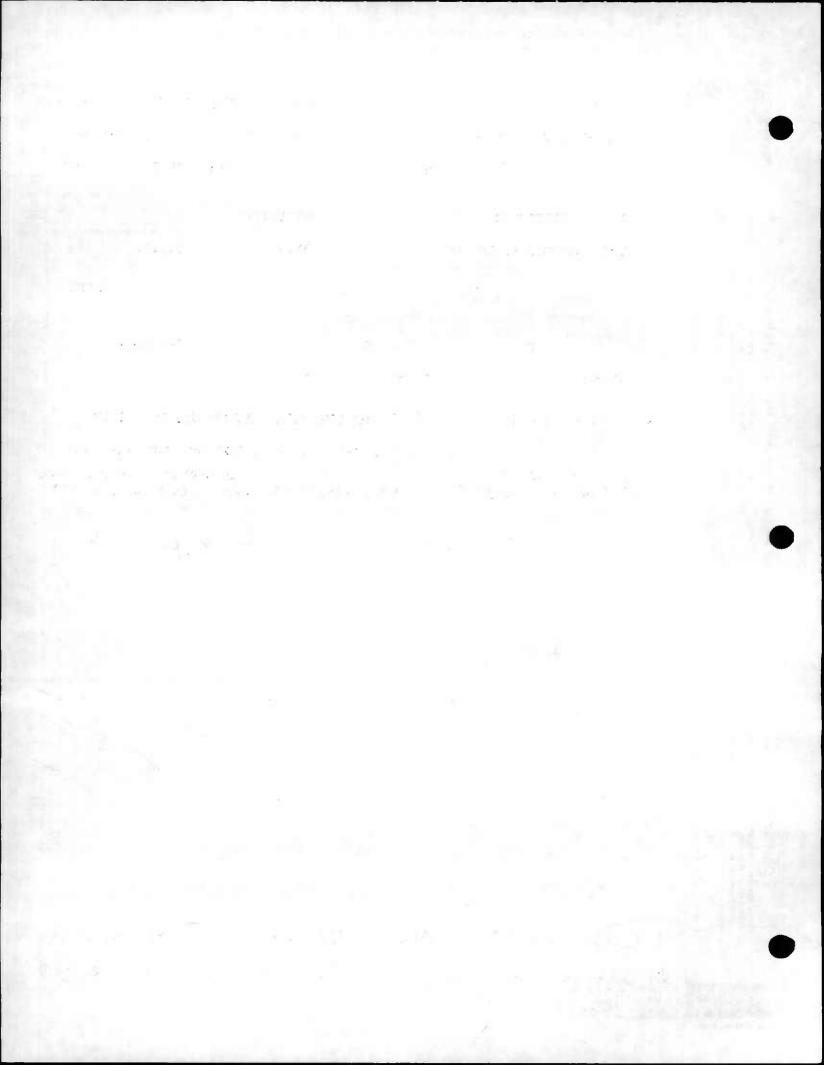
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30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Ra Old 4000 Court

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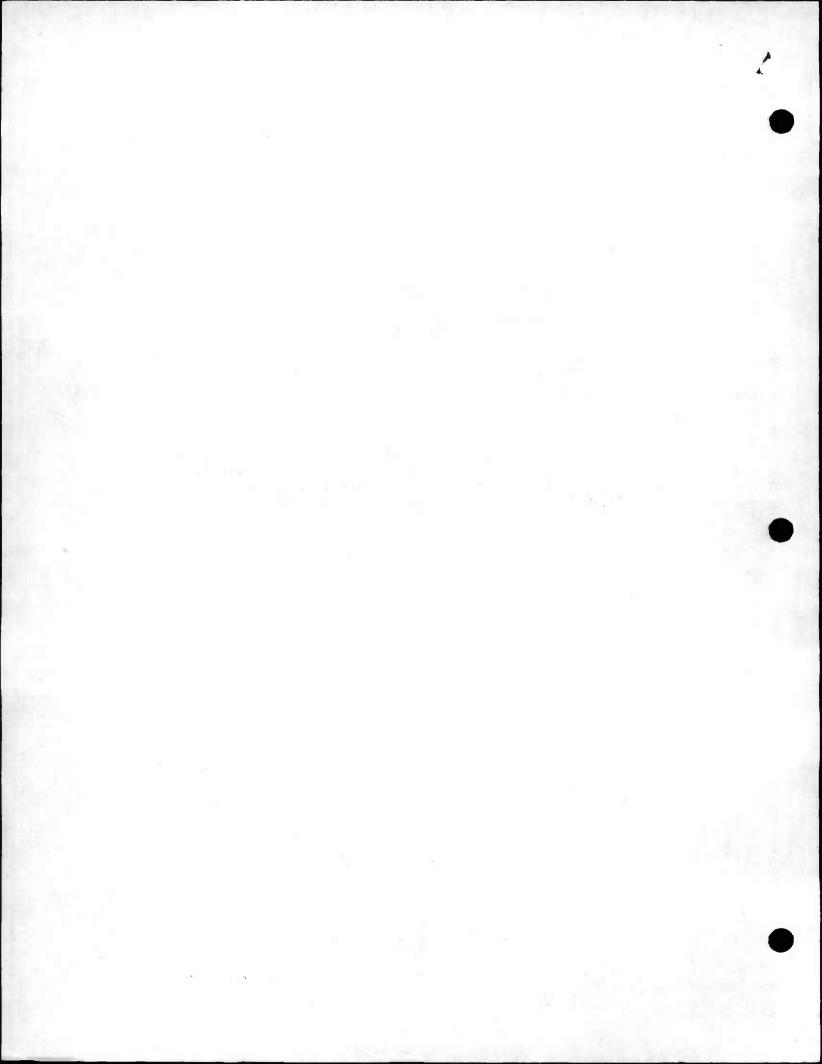


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 27, Ellen West 1998 July 4:30 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1832 Potomac Road Edgewater Anne Arundel If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foraign Country) **Funeral** 10M 20XF Days Hours 80 Yrs. Director July 20. 218-07-5017 1918 Virginia Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23s or 28s-f show t ☐ Yas 2 No Director Virginia Accomac Chincoteague 10e. Street end Numbar 10f. Zip Code 10g. Citizen of What Country? death with 8226 Sea Shell Drive 23336 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No It Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours aftar t Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Exercities. 1 Nevar Merriad 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White Specify: þ 3 M Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 10 Secretary Aero Space 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Unknown Hutchins Bessie Unknown 2 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Hartman E. Simmons - Son 8277 Elvaton Rd., Millersville, MD 21108 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 D Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Jul. 29 Glen Burnie, Maryland 21. Signature of Funeral Service Licen 22. Neme end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cardiac or aach line. Approximata Intervel Between Onset and Death **Physician** Immediata Causa (Finat disaese or condition rasulting to death) /Medical Stage IV Non Hodgkins 4 years Examiner Due to (or as a consequence of): Physician/Medical Examiner Lymphoma Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaasa or Injury Dua to (or as a consequence of): P.O. Box 68760, thet initiated evants rasulting in death) Last Dua to (or es e consequence of) The law requires that the death certificate Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, should be d þ 24b. Ware eutopsy tindings available prior to completion of cause of deeth? Be Completed 24a. Wes en autopsy performed? 1□ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa ratarred to medical 26. 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Certifian completaly (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. within 2 \$ 29b. Signature and title of certitier 29c. License number 29d. Data signed (Month, Day, Year) D27938 July 27, 1998 30. Nama and address of person who complated causa of death (Nama 23a) (Type, Print) Mayer Gorbaty 795 Aquahart Road Glen Burnie, Maryland 21061 31. Data tited (Month, Dey, Year) 32. Registrer's Signatura State the Davidson Rendess JUL 281998 Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath 3. Tima of Deeth Day Month Year **Physician** SIDNEY 23 1998 0945 Juh /Medical 4b. City, Town, or Location of Death ity Nama (If not institution, giva street and numbe 4c. County of Death Examiner CANDALLS TOWN KAUTIMORE Northwest tosoitar If Undar 24 Hrs.
Hours Min.

8. Date of Birth
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JULY 14, If Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Sacurity Number Sax 12 M 2□F Birthplaca (Stata or Foraign Country) Funeral Months Days Vre Director 103-09-7336 Usual Rasidanca of Dacedant the Merylend 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No BALTIMORE Director MD BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 21208 permit. Pages 1 and 2 should be filed within 72 hours aftar daath v Departmant of Haalth end Mental Hygiena. Important: if Itam 27 is marked other than "natural", or Itams 23a any Injury or other traumatic event, the Medical Examiner material. U.S.A. Funeral 4734 BYRON ROAD 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puano Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☐ No If Yes, Giva Yaer or Detes: 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify. Specify WHITE þ WWII XX Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) MACHINIST BETHLEHEM STEEL 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be YATROFSKY KATE CAROWITTZ SAMUEL 10 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 3800 MONTEREY ROAD BALTIMORE, MD 21218 JOHN FRUM (NEPHEW) 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 Cramation 3 Ramoval from Stata MARYLAND VETERANS GARRISON 7/27/98 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Othar (Specify) nature of Funeral Service 22. Nama and Addrass of Facility SOL LEVINSON & BROS., MD 21208 8900 REISTERSTOWN ROAD PIKESVILLE, 3CA a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Daath **Physician** Immediate Cause (Finel disaesa or condition resulting in death) VENTRICULAR /Medical Examiner Dua to (or as a consequence of) Examiner PRONANY years sician and burial-fransit Hrkru The law requires that the death certificete be axecuted Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated avants Due to (or es a consequance of Division of Vital Records, P.O. Box 68760. physician Physician/Medicai tha Dua to (or as a consequence of) rasulting in daath) Last usa es signed by the a Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mellitus þ 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy HULMONANY page 2 1 Yas 2 No 2 000 1 Yas cartificata Hospital or Attending Physician: 24 hours after death. diractor, Be 25. Was cese rafarred to medica axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Phoatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 10 1 Yes 2 No this funaral 28c. Injury at Work? 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: After 1 Natural 5 Panding after death. 1 Yas 2 No 2 Accidant investigation 6 Could not be determined 3 Sulcida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) in by 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to tha causa(s) and mannar as statad.

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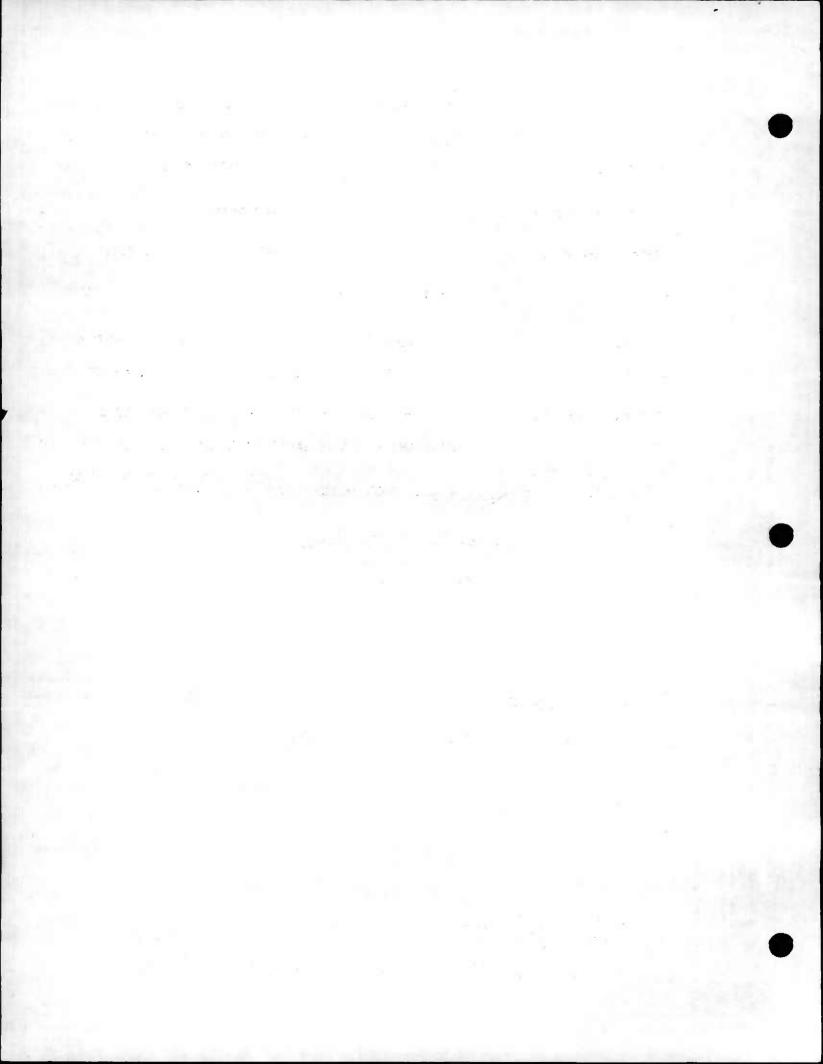
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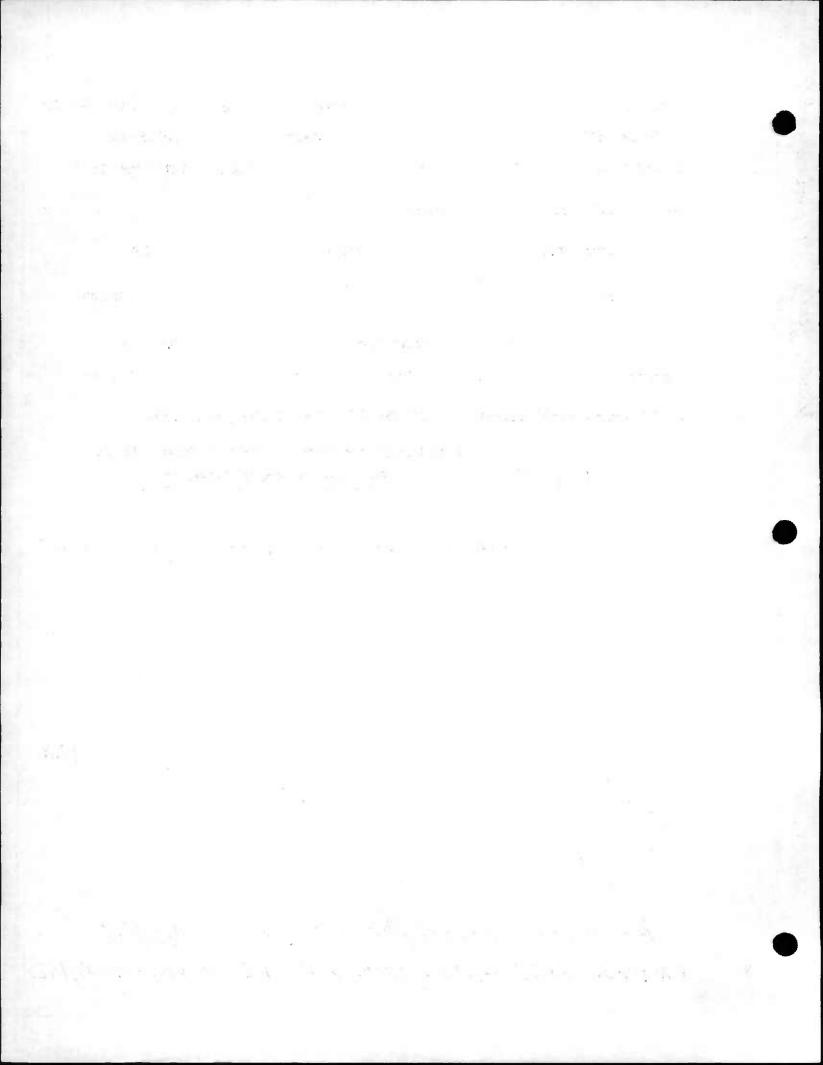
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P.O. Box 68760 Division of Vital Hospital or Attending 24 hours after death.
 Funeral Director: After a principle of the principle of in by t To the Hosp within 24 hou To the Fune completely fi

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Loma K. Zissimos 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street end number) 4c. County of Deeth Riverside Nursing+Rehab Hartord 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 1□ M 25 F 81 212-14-3125 Dec 9, 1916 Maryland Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Maryland Harford Co Belcamp 10g. Citizen of Whet Country? 10e. Street end Number 10f, Zip Code 1123 Belcamp Road 21017 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried Specify: White 1 ☐ Yes 2XXNo Specify: 3℃Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Samuel Day Loma Krout 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 310 Kennard Avenue, Edgewood, Maryland 21040 Date , 20c. Location - City or Town, Stete Joseph Zissimos (Son) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete Dulaney Valley Mem Gardens 7/30/98 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) CARDIO VASCULAR DISEASE ARTERIOSCLEROTIC Physician/Medical Examiner HYPERTENSION Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probabty 4 Unknown HYPOTHYROIDISM à 24b. Were eutopsy findings eveilable prior fo completion of cause of deeth? 24a. Wes en eutopsy Completed performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Death (Check only one) exeminer? Other: Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deetl 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, streef, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Descritying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

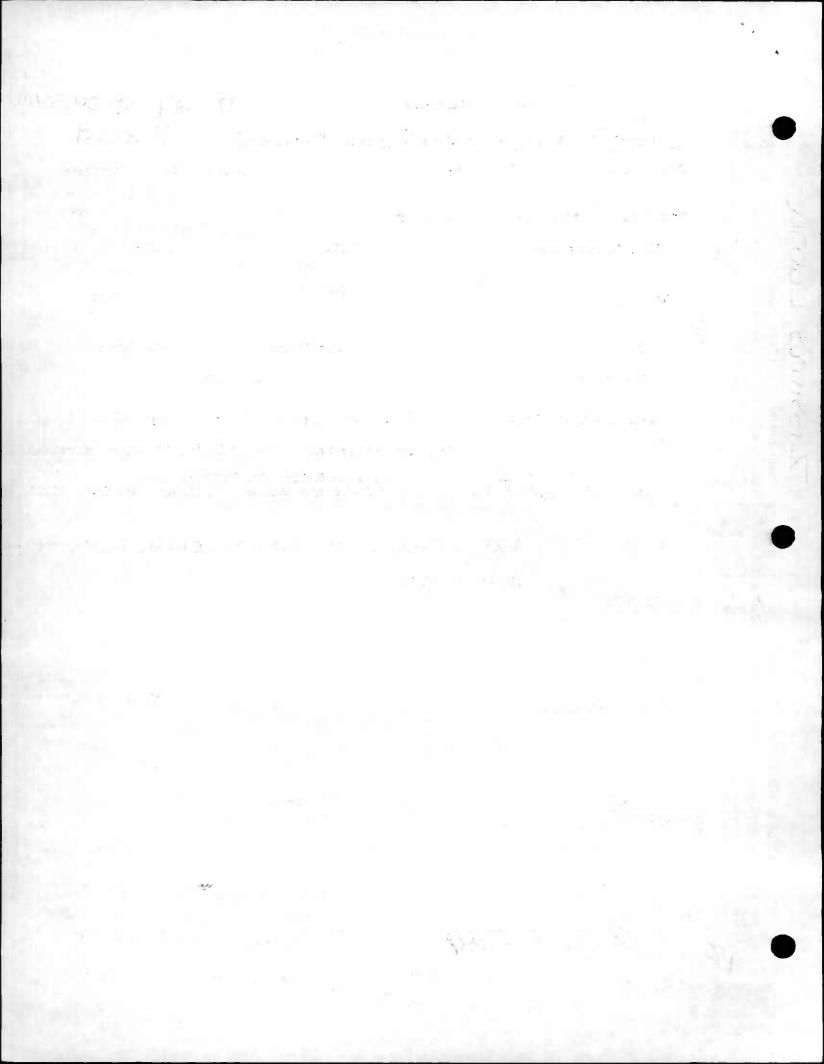
| Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Edgewood 31. Date filed (Month, Day, Year) reha Davidson-Randell 32. Regis 3/ JUL 281998 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 16 Rev 6/95

MANY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month **Physician** 6:11 Dule DLLIE 4c. County of Deeth 24 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Geeth **Examiner** Union Memorial Hospital Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year | 11 Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Deys 1 M & SELF 69 Yrs 222-16-0521 Director 03-16-29 NC Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryler Department of Health end Martiel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination or natified at each 1 No 2 No MD Director Baltimore 10f. Zip Code 10g. Citizen of What Country? Apt.206 1010 W. Baltimore Street 21223 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 3 No Specify: Specify: Black þ 3 ₩idowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Cenntennial One 8th Grade NA 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Enoch Spence Rosie Lowery 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21213 Shirley 3317 Elmora Avenue Baltimore, Maryland J. Armstrong 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State M d . 1 Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forest VA Cem. 07-30-98 Owings Mills re of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue or emplications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, the only one cause on each line. Approximete Intervel Between Onset end Deeth 23a. Pert Enter the diseas shock, or heart failure. **Physician** immediate Ceuse (Finel disease or condition resulting in deeth) an Failur /Medical Examiner Due to (or a a conseque Physician/Medical Examiner epses The law requires that the death certificete be executed ettending physician end for use es the buriel-tren Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequence of) P.O. Box 68760, that initieted events resulting in deeth) Lest Due to (or es e consequence of) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy certificate hes b 271 No 1 Yes 1 Tyes Division of Vital Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpetlent 2 3 DOA 2 Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Affer Attending Natural 2 Accident 5 Pending Investigation injury death. 1 Yes aher death Director: 6 Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier adical to the 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Dev. Yeer) 112438946

MEMORIAL HOSPITA

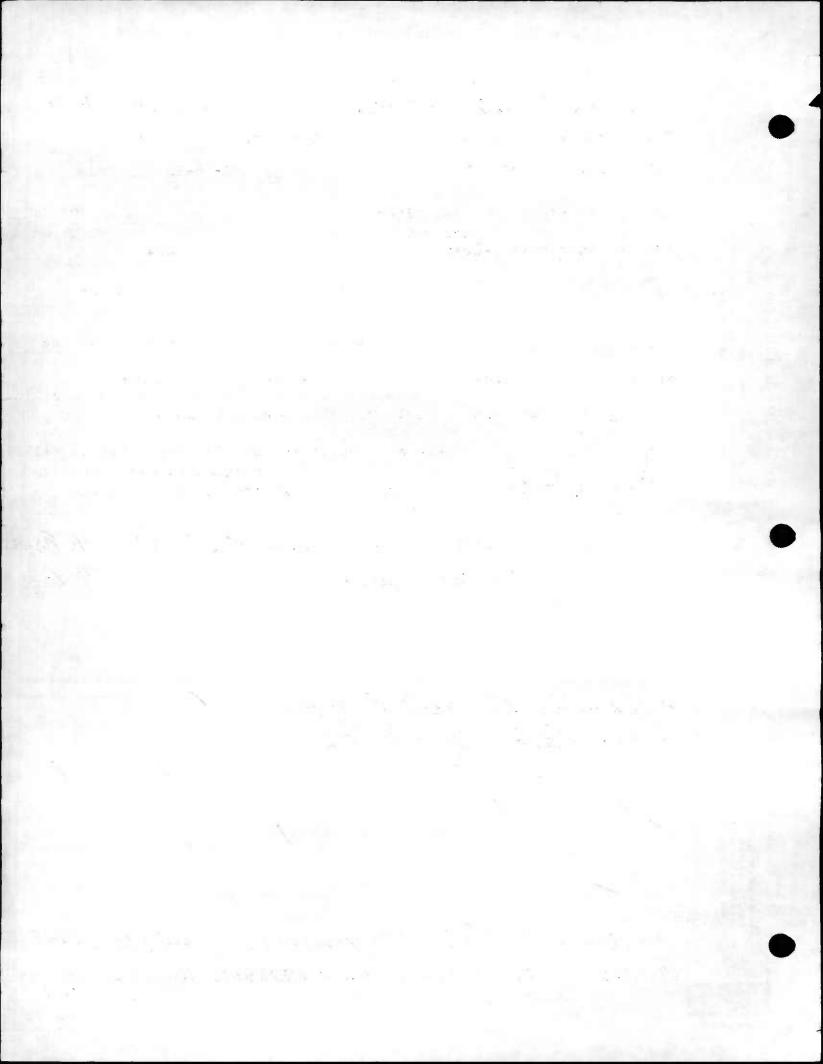
UNION

State Registrar 30. Name end eddress of person who completed cause

Ye2'91998

32. Registrar's Signature

una Davidson-Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month 05 P.M Kueben 1998 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth hildren 405 Galfmare If Undar 24 Hrs. Hours Min. 8. Dete If Undar 1 Yaar Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Deys Months 10 M 20 F -38-508 20-1936 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore NA 1 Per 2 □ No Ma 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 21215 4103 Eldorado 5.A , 12. Wes Decedent Ever in U,S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Yaer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Merital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Teachers Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Organizations Union) years 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Clemons elchor Hice Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 410 Avenue Eldorado Balfo, Mel 21 Oc. Location - City or Town, State 21211 alona 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location 1 M Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) troutus. 22. Name and Address of Fecility of Funeral Service Lice . West Balto, nd 21215 Wabash 4300 ations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Immediate Output (Fi disease or condition resulting in death) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Ph sician /Medical **Examiner**

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After this

24 hours efter death.

To the within 2

completaly filled in by tha funeral director,

Hospital or Attending Physician:

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Certification:

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The law requires that the deeth certificata be execu

Division of Vital Records, P.O. Box 68760,

Dapartment of I

Injury or

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Examiner

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Pagas 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena.

ant: If item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinal must be notified at

altimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Physician/Medicai

25. Was case referred to medical exeminer?

1 ☐ Yes 2 No

27. Menner of Death

1 Natural

2 Accident 3 Suicide

4 C Homicide

29a, Certifian

23a, Part1,

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. ANEMIA

GASTRO INTESTINAL BLEEDING

Hospital:

5 Pending Investigation

6 Could not be detarmined

2 No 1 ☐ Yes 2 ☐ No 1 Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

 Location (Street end Number or Rurel Route Number, City or Town, State) 28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29c. License number 29b. Signature and title of or

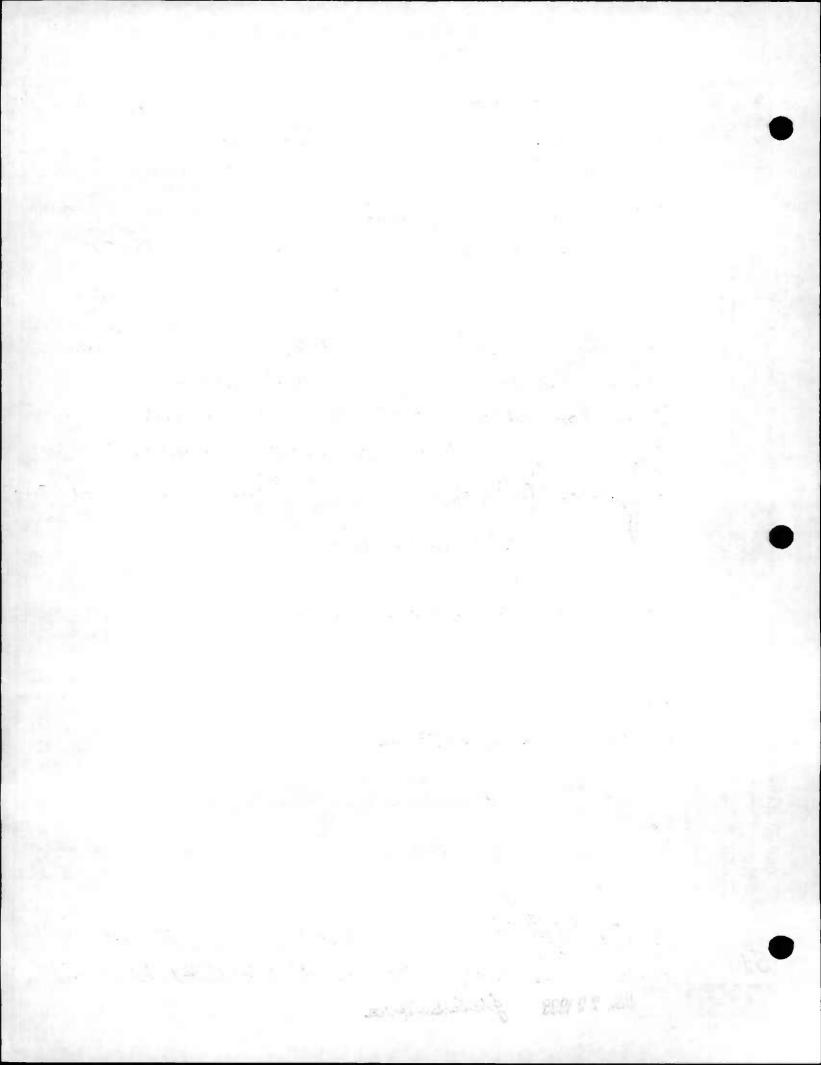
Aha Davidson

29d. Dete signed (Month, Dey, Year)

lipleted cause of daeth (Item 23e) (Type, Print)

3901 CREENSPRING SUITE 301 EREEDMAN MO 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month 50 1998 a.M. Margaret Anderson 4b, City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Balt more If Under 24 Hrs. 8. Data of Birth (Month, Day, NA DELVEGELE Mic If Undar 1 Yaar 9. Birthplaca (State or Foreign Country) 5. C. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Deys 216-84-8479 1 M 2 YF 35 Vrs may Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 □ No NA ma +i more 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? BELVEDERE 2121 NSA 13. Was Dacedant of Hispanic Origin? (Specify Yas or Noif Yes, specify Cuban, Maxican, Puerto Rican, atc.) 12. Wes Dacedenf Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No 1 Yes 2 No Specify: Specify: 3 ☐ Widowad 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) NA NEMP 12+4 NA 0 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Anderson ulloug OSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zig)Coda) Balto. Md. 21215 Mic Anderson-Mother 3128 Virginia 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) Kandall YOUT 22 Nama and Addrass of Facility 21. Signatura, of Funeral Service Licansaa ERO TOME 4300 Wabash tame 23a Part. Enter the deaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about or huart halure. List only one cause on each line. Approximate Interval Batwaan Onsat and Death auti 12 hi Immadiata Causa (Final disaasa or condition rasulting in daath) Due to ko Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury Dua to (or as a consequence of) that initieted evants rasulting in death) Last Dua to (or as a consaquenca of). 23b. Did tobacco use contributa to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown rent 24b. Wara autopsy findings eveilabla prior to complation of causa of daath? 24a. Wes en eutopsy 1 TYes 2 □ No 1 Yas 30 NO 25. Was casa refarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Aasidence 6 Other (Specify) 2 1 No 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Daath 28c. Injury at Work? 28a. Data of tnjury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

1🕱 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29c. Licansa number

29d. Date sigged (Myhth, Pay, Year)

Examiner attending physician end for use es the buriel-trensit The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, Se esn is signed by the a this certificate or Attending Physician: director, After this funerel d death. Director: /

Physician

/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Certification: To

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29a. Certifian

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any injury or other traumatic events any linjury or other traumatic events."

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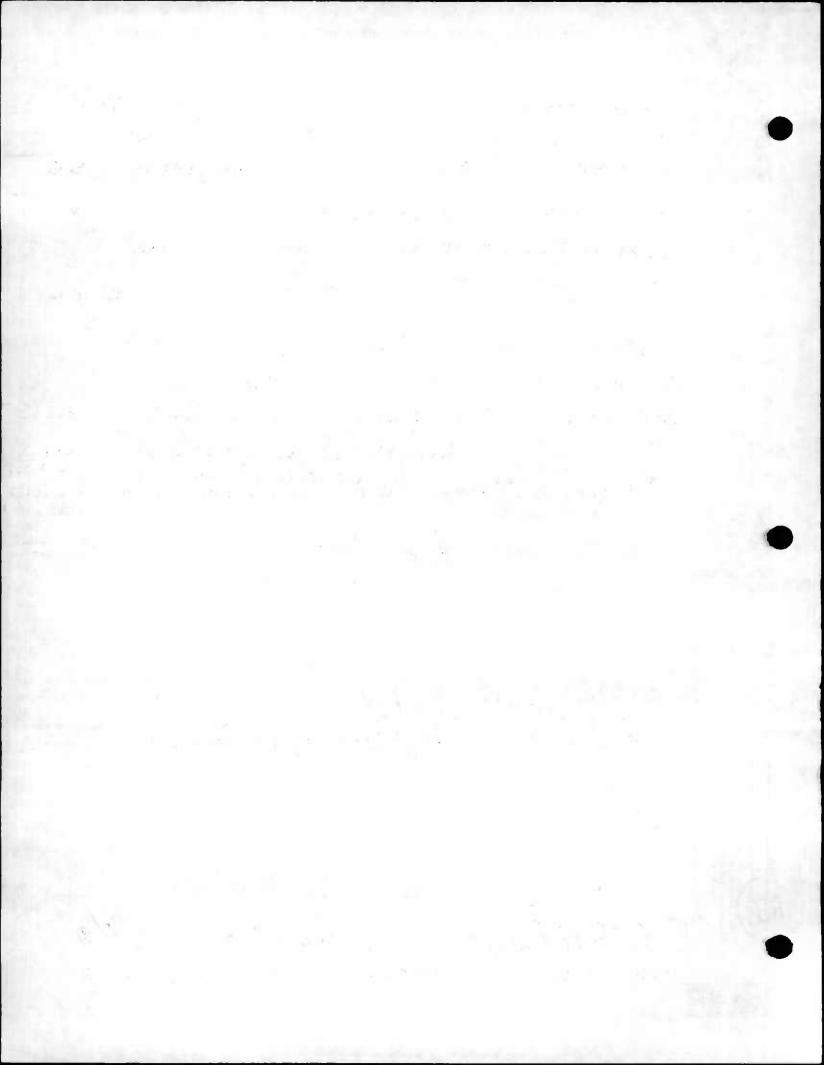
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Who completed cause of death (Itam 23e) (Type, Print) 30. Nema and address of person LEVY ROBERT I M. D. 31. Data filad (Month, Day, Year)

GREENE TREE RD BALTO, MD 32. Registrar's Signal un Devidson

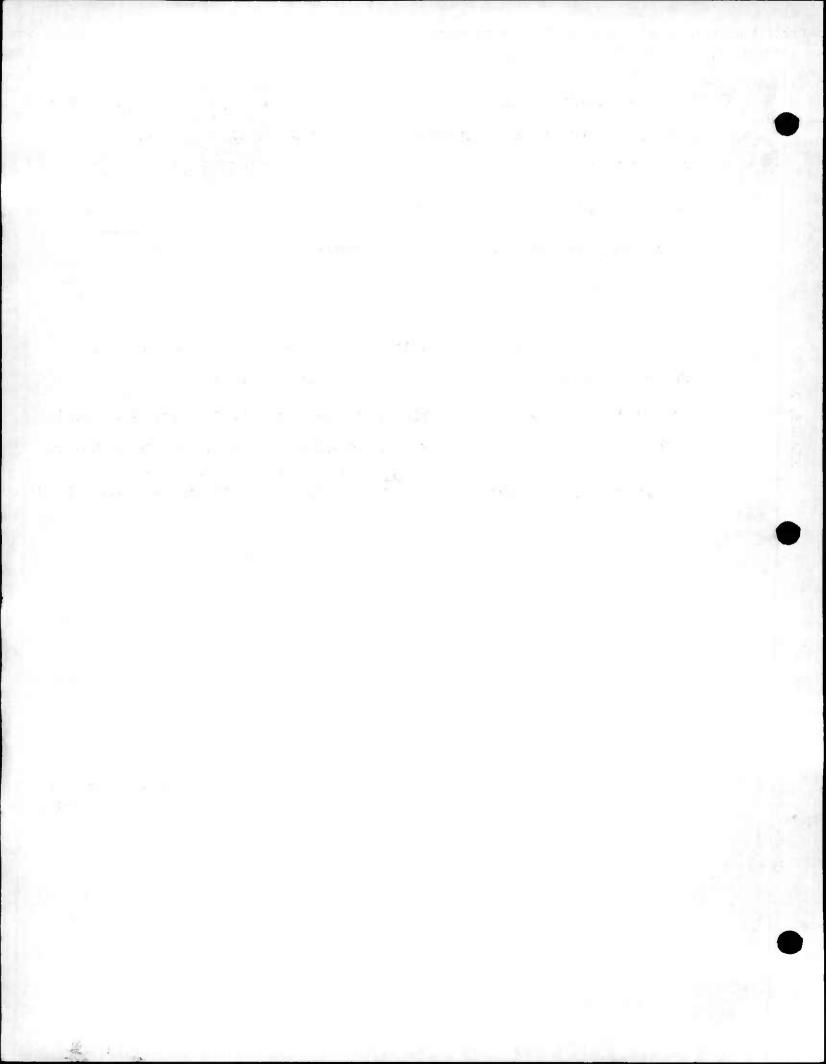
Registrar

29b. Signature and little of cedifier



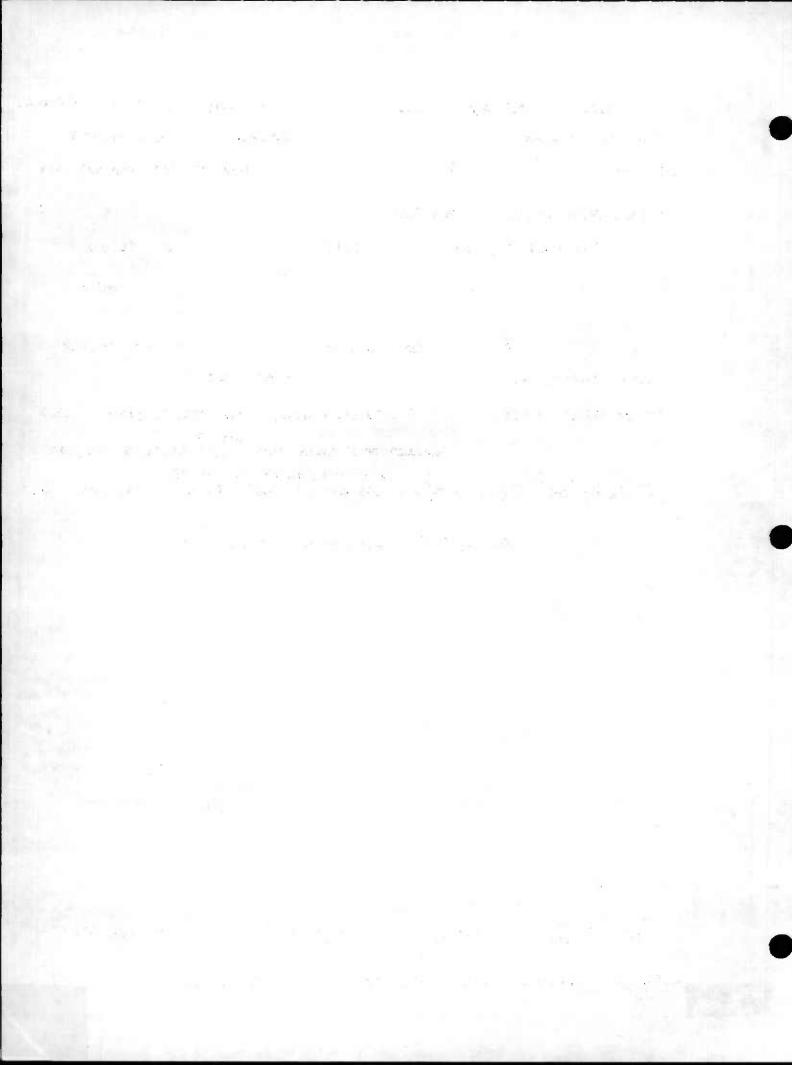
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Funeral Director		5. Sociel Security Number 218–18–6255	Sex 1 № M 2 □ F 7. Age (fn	yrs. last birthda; Yrs.		Year If Under 24 Hrs Deys Hours Min.	8. Date of Birt (Month, De July 30	v. Year)	9. Birthplace (S Country) MD	State or Foreign
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With With	吉	10e. Street end Number			10f. Zlp (10g. Citizen ot V	Whet Country?	
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s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, it a Medical Exaction (1.41) be notified a	by Funeral	11. Maritel Status 1 □ Never Married 2√2 Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If 4es, Give Yeer or Detes:	in U,S. 13		nt ot Hispenic Origin? (S y Cuban, Mexicen, Puer XNo <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	Specify	e - Americen Indi ck, White, etc.	
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permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than sny Injury or other traumatic event, it a Meone.		20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Special Content of the Content	Removel trom State		ematory or oth	er place)	7-30-98		City or Town, St	
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/Medical		Immediate Ceuse (Finel disease or condition	META	STATIC	Pan	THIE C	ANCER		0	years
Examiner		resulting in death)	θ	to (or es e conse	-	,,,,				/
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ding Dr.: Atler s tune	cation:	1/⊠Naturel 5 ☐ Pending 2 ☐ Accident investigati		(r) Injury	М	injury et Work? 1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,		
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		Ann 20 - 1 do - 1 do - 1	Later Division in					3 /		
		31. Dete tiled (Month, Day, Year)	3. Registrar's S			salto, a	0 212	36		



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											Reg. No.			
alam I	1. Decedent's Name (First, Mid	idle, Last	t)							2. Date of D Month	eath Dey	,	Year	3. Time of Deat
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iner	4a Facility Name (If not institute	100		imber)			4	lb. City, To	wn, or Lo	cation of Dea	th 4c.	County of	f Deeth	
	963 Duvall I	High	way						aden			Anne		
ıl	5. Social Security Number	6. Se	X M 2□F		rs. last birthda	y) If Unde Months	Days	If Under Hours	Min.	8. Date of B (Month, D	irth lay, Year)		9. Birthp Coun	lace (State or Fore
r	213-18-0054			78	3 Yrs.					Nov. 1	3, 19	919 P	enns	ylvania
}	Usual Residence of Decedent 10s. State 10b. Coun	ity		10c.	City, Town or	Location							1	0d. Inside City Lim
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Director	10e. Street and Number					10f. Zii	p Code		·		10a, Citi	izen of Wi	het Coun	ntry?
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F	1 ☐ Never Married 2 ☐ Ma	arried	Armed F 1 ☐ Yes	orces? 2⊠No ive						Rican, etc.)			, White,	
by	3 ☐ Widowed 4 ☐ Divorce		If Yes, G Year or I	ive 11 Dates:		1 ∐ Yes	2XI No	Specify:				Specify:	WIII	.te
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To	Daniel Allow	vay,	Sr.					Re	becc	a Mark	e1			
	19a. Informant's Name/Relation									al Route Num	ber, City o	r Town, S	State, Zip	·
	Trecie Allow	vay /	/ wife			Duva			У	Pasade	T			21122
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death MARGARET 30 BARTS am JULY 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BAYVIEW MEDICAL CONTRE BALTIMORE MARYUAND INHOU HOPKINS 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 81 Yrs. 81 Yrs. U1y21, 1917 Maryland 5. Social Security Number 1□ M 20 F 219-30-7458 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 3 ☐ No Baltimore Fort Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9130 Todd Ave. 21052 USA 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 yrs. Housewife Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Loyd Bowers Wilhemia Aspelmere 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sally Waszelewski daughter 9200 Todd Ave. Fort Howard Md. 21052 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) July29, Parkville, Md. 21236 Parkwood Cem. 22. Name and Address of Fecility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road 21222 h? wn

Physician /Medicai Examiner

Physician

Funeral

Director

rai', or items 23s or 28s-f show Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Depenment of Health end Mental Hygiere. Important: if Item 27 is merked other than "natural, or items 23s any filury or other traumatic event, the Medical Examiner matal defines.

Baltimore, Maryland 21215-0020

Director

Funeral

Completed by

Be

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Md.

/Medical

buriel-tren

or Attending Physician: The law requires that the death certificate be executed

of Vital Records, P.O. Box 68760.

Division

shock or heart failure. List only	euse on each line.	stil. Do not enter the h	lode of dying, such es cardi	ac or respiretory errest,	Intervel Between Onset end Deeth
Immediete Ceuse (Final diseese or condition resulting in death)	· CEREBRA	TL HAER	MORRHAGE		18 hours
,	Due to	(or es a consequence o	of):		
Sequentially list conditions, if eny, leading to immediate	b. Due to	(or es e consequenca o	of):		
if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c Due to (or es e consequence o	f):		
	d				
Pert II. Other elgnificant conditions of	ontributing to death but not re	sulting In the underlyin	g cause given in Pert I.	23b. Did tobacco uee contribu	ute to the cause of death
				1 ☐ Yes 20 No 3 ☐	Probably 4 Unknow
				24e. Wes en eutopsy performed?	b. Were eutopsy findings eveileble prior to completion of cause of deeth?
				1 □ Yes 2 No	1 ☐ Yes 2 No
25. Wes case referred to medicat examiner?			26. Place of De	eeth (Check only one)	
1 Yes 2 No	Hospitel: 1 Inpatient 2	☐ ER/Outpetient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (S)	pecify)
27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury et Work? 1 \(\text{Yes} \) 2 \(\text{No} \)	28d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, fact	ory, offica	28f. Location (Street end Number or City or Town, Stete)	Rural Route Number,
29a. Certifier (Check only one)	ysician: To the best of my kniner: On the basis of examination and menner steted.	owledge, death occurre ation end/or investigeti	ed et the time, dete end plec on, in my opinion, deeth occ	e, end due to the cause(s) end menner curred et the time, date end pleca, end c	es steted. due to the ceuse(s)
29b. Signeture and title of certifier		2	29c. License number 9 70 1 8	29d. Dete signed (Mo	onth, Dey, Yeer) 7th 1998

CHHOC

HOPKING BAYVIEW MEDICA CENTER

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

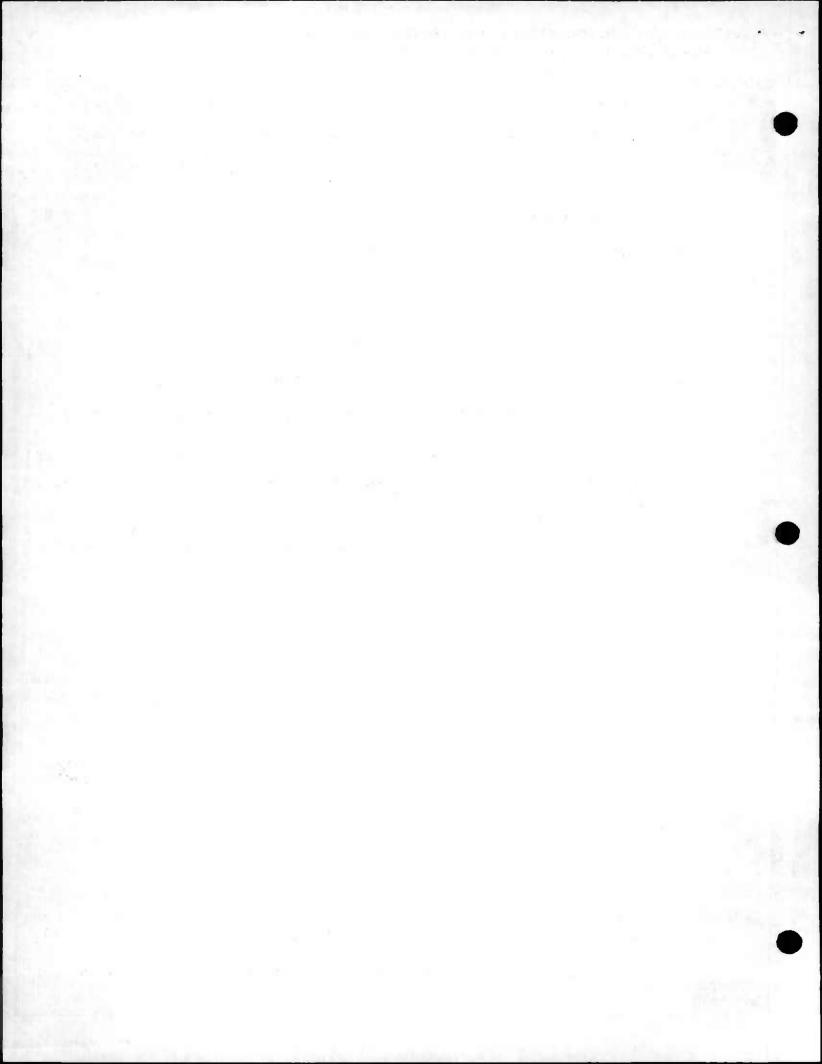
KESWAN

32. Registrar's Signature

SANJAY

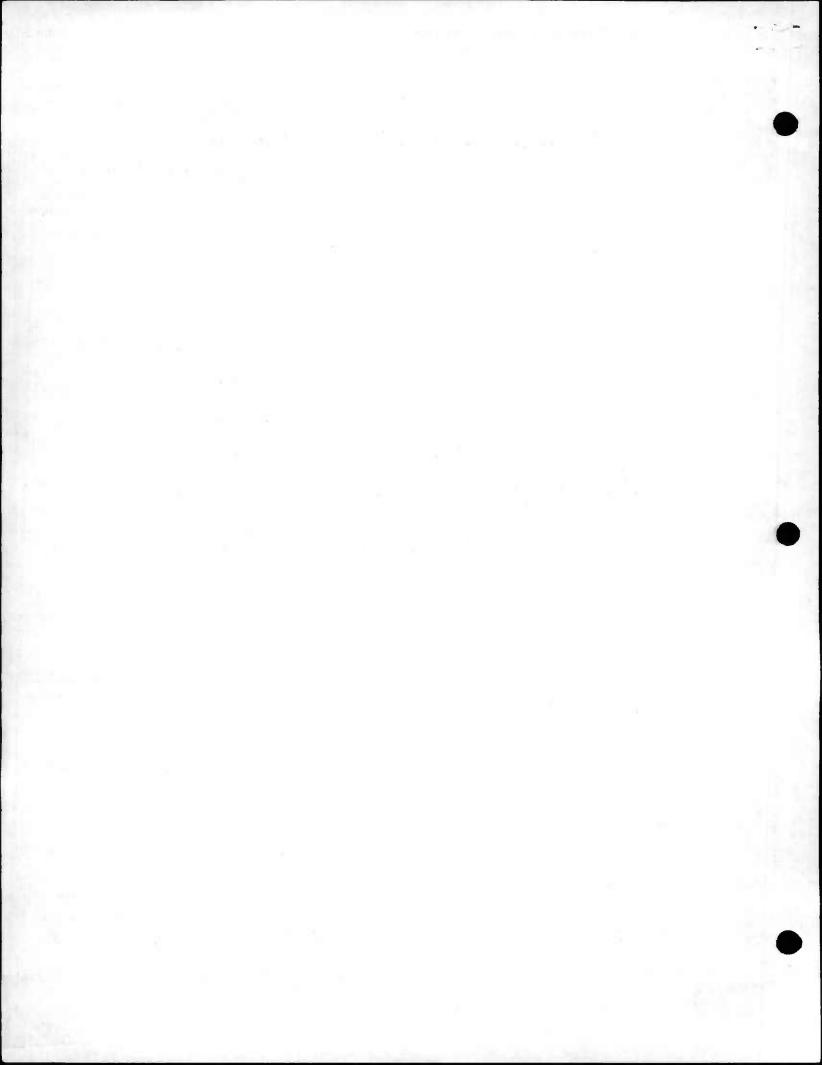
31. Dete filed (Month, Day, Year)

State Registrar



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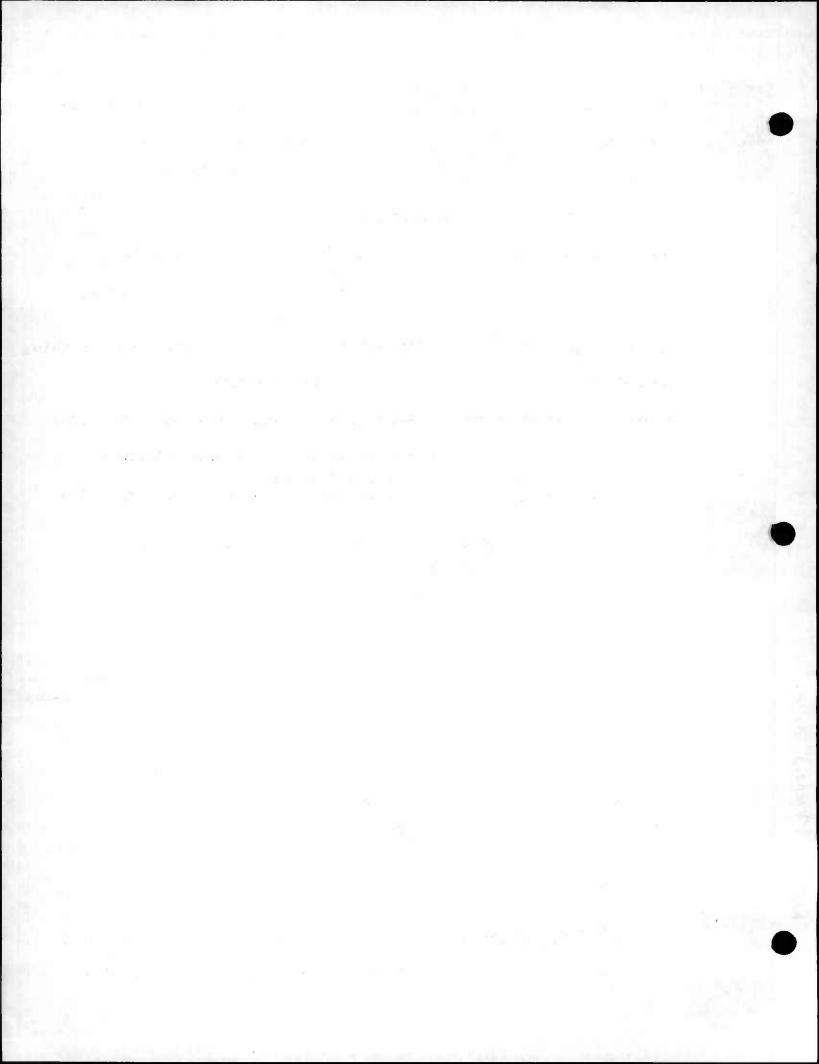
	_						Ce	rtificate	of E	Death	R	eg. No.	
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	/Medi		Daniel				1010	cki			July	1	98 08:30 Am
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L			Johns Ho		ayure		dical	Cente	4		more	N/A	
	Funeral Director		5. Social Security Number 216-18-4397	6. Sex 1 🖾 M 2 🗆		e (In yrs. le 7	st birthday, 5 Yrs.	Months I	Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey June	21,1923	B. Birthplece (Stete or Foreign Country) B. Maryland
-			Usuel Residence of Decedent										7
	show adat		10a. State 10b. Cou	nty		10c. City,	Town or L	ocation					10d. Inside City Limits
	death with the Maryland ris 23s or 28s-f show .must be notified at	Director	Md. Balt	imore		Dun	dalk						1 ☐ Yes 2 [A] No
	# 28 P	ire	10e. Street end Number					10f. Zip C	Code		1	log. Citizen of Wh	at Country?
	e Sa		1762 Langpor	t Ave.				212	22			USA	
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Maryland 21215-0020	hours after burst, or He at Examine	by	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divor	lerried 15	Yes 2 Nes, Give	No		1 Yes 2		Specify:	ricari, etc.)		White, etc. Thite
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, La 2. Data of Deeth 3. Tima of Death Month Dev **Physician** 24 1998 11:10 AM Th-e COKS July /Medical 4e. Fecility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore
If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, MichAEI JA If Undar 1 Yeer Birthpiece (Steta or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Deys 1□ M 2)2 F 68 217-24-4678 Usual Rasidance of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f shor ty⊠ Yas 2 No BAltimore Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? S.A 21207 Funeral NACA 3 12. Was Decedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Z No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedant's Education 16a. Decedent's Usuai Occupation 16b. Kind of Businass/Industry (Specify only highest grade complated) (Giva kInd of work dona during most of working lifa. DO NOT usa retired) marked other than Eiamantary/Secondary (0-12) College (1-4or 5+) Hygiene 8+H G-RADE MD. School for the Blind AUSE KEEPING NA 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be and 2 should be ealth and Mental BAILEY Ethel 2 MARRY HANDU 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) of Health and I fram 27 is n 20b. Plece of Disposition (Nama of cematary, cramatory or other placa) Balto ICTORIA Pages 1 a 20e. Mathod of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Ramoval from State MEMORIAL 7/30/98 RANDALISTOWN, MD 22. Name end Address of Fecility
Wm. C MARCH F 21. Soneture of Funeral Service Licer 23a. Papar Entar tha disaase, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock or heart failure. List only one cause on eech line. Home WEST INC 21215 **Physician** Immediat J ausa (Final disease o condition resulting in death) /Medical rscase Examiner Dua to (or as a consequence of). Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Saquantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseasa or injury thet initieted avants rasulting in death) Last Dua to (or es a consequança of): Dua to (or es a consequança of) signed by the a Part II. Other elignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Onknown 1 ☐ Yes 2 ☐ No ò 24b. Wara autopsy findings availabla prior to complation of causa of deeth? Completed 24a. Was an eutopsy performed? cartificata has 2 No 1 🗆 Yes 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? Be 26. Placa of Death (Check only ona) Othar: 3000 2 1 Yes 1 Inpatiant 2 ER/Outpatient 3 DOA 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) this 28c. Injury a Work? 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how injury occurrad Medical Certification: Aftar Natural 5 Panding Injury Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datamined 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stete) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, P.O. Division of Vital Records, n 24 hours must he Funeral Director: A within 2 To the I

State

29a. Cartifiar

Registrar

Kayman Miller 31. Date filed (Month, Day, Year)

JUL 291998

29b. Signatura end titla of cartifiar

Morn Street , soute 200 32. Ragistrar's Signature

and manner stated.

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

25

🚅 Cartifying Phyelclen: To tha bast of my knowladga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On tha basis of examinetion end/or invastigation, in my opinion, death occurred et the time, date end placa, and dua to tha causa(s)

29c. Licensa numbar

Rentestown

29d. Data signed (Month, Day, Year)

mo

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Baze 25 1998 02:30 am July /Medical 4e Fecility Neme (If not Institution, give streat end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Greater Baltimore Medical Center **Baltimore** Towson 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral^a Deys Hours Months 1 M 2 KF 73 Yrs. 403-32-2179 Director 7-24-1921 Usuel Residence of Decedent 10e Stete 10c. City, Town or Location 10d. Inside City Limits 1 PYes 2 □ No Baltimore Directo Иd 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number nust be r 5/32 Vembridge 21215 Avenue Funeral 14. Rece - American Indien, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Merital Stetus 1 ☐ Never Mamed 2 Married 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1□ Yes 2XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced marked other than "natural", matic event, the Medical Ex Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Mercy Hospital Elementery/Secondary (0-12)
12:49 grade College (1-4or 5+) Nurses 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Montal H Bessie John 4. Norms Moseley Pages 1 and 2 should 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Baze Robert Balto, rd 21215 Husband Avenue Pembridge Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State Forest 7-30-98 OWINGS 4 ☐ Donetion 5 ☐ Other (Specify) nournson 21. Signature of Funeral Service Licens 22. Name end Address of Facility 1arch F. H. West 4300 wabas wabash Avenue Balto, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete tntervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Encephalopathy disease or condition resulting in deeth) **Examiner** bue to (or es e consequence of): Examiner Acidosis Due to (or es e consequence of): The law requires that the death certificate be executed physician and sthe buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Sepsis

Due to (or as e consequence of): P.O. Box 68760. Physician/Medical se esn signed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? Diabetes mellips Division of Vital Records, þ 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy typerforsion performed? is certificate hes t director, page 2 s 1 Yes 2 2 No 1 ☐ Yes > No ai or Attanding Physician: The safter death.

I Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpetient 3 DOA 1 Yes ≥ No Certification: To 28c. Injury et Work? 28e. Date of injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours a 24 hours a Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

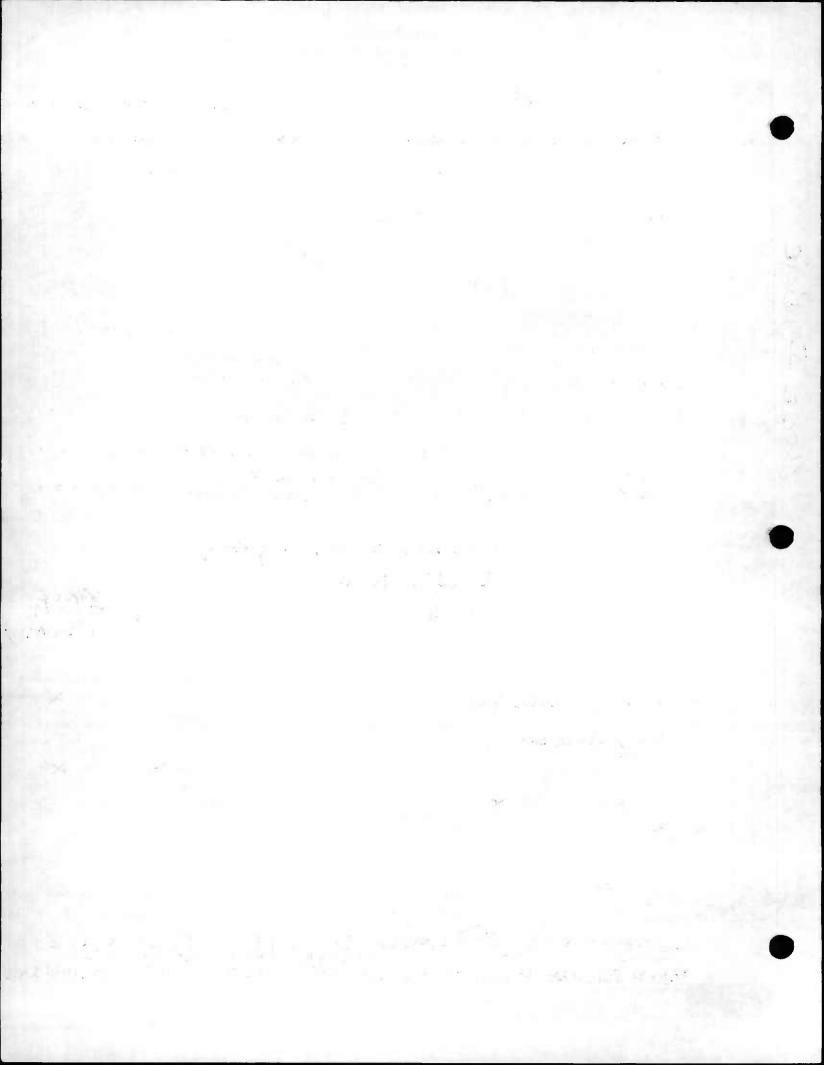
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) re the within To the com 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Dev. Year) ress of person who completed cause of deeth (Item 23e) (Type, Print) WHTE HUMSH TULY 25, 1998 HEDICAL CENTER

MARS JUDEUNE MINEY ITO M.D. 4700 CAMPBELL
31. Deter filed (Month, Dey, Year)
32. Registrer's Signature

BAUTI MORE, MARYLAND

BLVD

State Registrar



Piease Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Otato of Mary		Certifica				Reg. No.	0 .	3129
Physician	Decedent's Name (First, Middle, Last)							Death Day	Year	3. Time of Death
/Medical	MELVIN BEC 4a Facility Name (If not institution, giv	, or Location of C		1998 County of Death						
Examiner	Saint Joseph		enter				son			imore
Funeral Director	215-24-6183	ex 7. Age (1/2)	n yrs. last birth	day) If Und Months	er 1 Year Deys		Min. (Monti	Birth h, Day, Year) t. 25,19		place (State or Foreign ntry) ryland
death with the Maryland me 23e or 28e-f show rmast be notified at meral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Ba	altimore	Oc. City, Town	or Location		Roseda	le			10d. Inside City Limits 1 ☐ Yes 2 No
uth with the Maryla 23s or 28s-f sho ust be notified at ral Director	10e. Street and Number 8509 Bassett Roa	en of What Cou								
	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Was Dec	edent of t	21237	? (Specify Yes o		4. Race - Ameri Black, Whita,	can Indian,
5-0020 72 hours after matural; or fin algal Examina	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give 1 S Year or Detes:	945-46			Specify:	deno rican, etc		Specify:	hite
72 h manu dicel	15. Decedent's Ed (Specify only highest gra		16a. [ecedent's Us Give kind of w	uel Occup ork done	oation during most o	f working	16b. Kind	d of Business/Ir	ndustry
21215-0 ed within 72 ho ygiene. er than 'natur 4, the Medical. Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)								
d 2	17. Father's Neme (First, Middle, Last)		Į įvi	etal T	estei		Name (First, Mi		teel In	dustry
fand be free free free free free free free f	Henry Becker						ia Blei			
Maryland 21215-0020 nd 2 should be filed within 72 hours at thit and Mental Hygiene. 27 is marked other than "natural", or resumatic event, the Medical Exam To Be Completed by F	19a. Informent's Name/Relationship (Mrs. Eleanor M.	**	1				or Rural Route N Baltimo:		Town, Stete, Zi 21237	p Code)
Baltimore, semit. Pages 1 ar Separtment of Hea montants if Item; my Injury or other side.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Hemovei from Stete	20b. Plece of the competery.				Data 7/29/199		ation - City or T	
Balti Permit. 1 Departm Importer any inju	4 Donation 5 Other (Specify) 21. Signeture of General Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland									
	23a. Part1. Enter the disease, or com shock or heart stilure. List only	olications that caused the	e death. Do no						yland	21222 Approximeta
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	CARDIAC							1 1 2	Interval Between Onset end Death HOUR
P Jie	Tooling II does !	POST- II	e to (or es e co VFARCT	nsequence of ION V): ENTI	RICULA	R SEPT	AL DEF	ECT	DAY
58760, certabe asseuted physician and s the burist-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									7 DAYS
Medicary	that initiated events resulting in death) Last		Due to (or es a consequence of): CORONARY ARTERY DISEASE 40 Y							
death cer death cer death cer death cer use	Pert II. Other significant conditions of	ontributing to death but n	ot resulting in t	he underlying	cause oi	ven in Pert I.	23b.	Did tobacco u	se contribute (to the cause of death?
15, P.O. Box res that the death ce- signed by the attendit i be detached for use by Physician/I								194Yes 2 No 3 Probably 4		
The law requires the state has been signed page 2 should be completed by							24a.	Was an autops performed?	ar C	Vere autopsy tindings vailable prior to ompletion of cause I death?
The law page 2									(No 1	☐ Yes 215KNo
Vital I	25. Wes case referred to medicat examiner?	26. Place of Deeth (Check only one)								
수 등등 는	1 ☐ Yes 2/1 No	Hospital: 1 tnpatient	2 ER/Out	atient 3 [JON		ing Home 5□	Residence 6	Other (Speci	ify)
DIVISION OF i or Attanding Physics after death. I Director: After this d in by that funeral ic	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		sar) 28b. Tii	na of ury M	28c. Inju Wo 1	ryat rk? ∣Yes 2⊡No		ribe how injury	occurred	
Division of the or Attanding Pra after death. al Director: After the or in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be detarmined	286. Place of injury	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						Number or Rui	al Routa Number,
Ne Hospi n 24 hou ne Funer pletsly fill edical	29a. Certifier (Check only one) 155 Certifying Ph	yeiclan: To the best of m liner: On the basis of ex- and manner stated	amination end/	death occurre or investigation	d at tha ti on, in my o	ma, date and popinion, daath	place, and dua to occurred at the t	tha cause(s) a ime, date end p	and manner as place, and due	stated. to the cause(s)
To the To the Common M	29b. Signeture and title of certifier Peter U	V. Clis N	ı.D.		9c. Licens 4113	se number			signed (Month)	, Day, Year)
641	30. Name and address of person who PETER CHO, M. D			ype, Print)	WSOI	N, MAR	YLAND	21204		-4 19
State Registrar	31. Date filed (Month, Day, Year) JUL 291	998 32. Regilirar's	Signifyre	Mandel	٤					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** BRADY JUNIOR ANDREW ALOYUSIS 1998 JUL 26 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BALTIMORE CENTER HARBOR HOSPITAL 5. Social Security Number 7. Age (In yrs. lest birthdey) if Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Day, Year) May 22, 1923 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 1 M 2 □ F 215-16-2762 75 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c, City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Mexical Exercical must be notified at 10d. Inside City Limits Director 1 Ves 2 No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1326 Cypress Street 21226 U.S.A. daath ' Funeral 12. Wes Decedent Ever in U,S. Auned Forces? 1 N Yes 2 □ No If Yes, Give Yeer or Detes: WW I I Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, permit. Pagas 1 and 2 should be filed within 72 hours eftar of Dapartment of Health end Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or item any Injury or other treumatic event. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Anne Arundel County Elementery/Secondery (0-12) 12th College (1-4or 5+) Police Officer Police Department 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Edith Martha Gardner 2 Andrew A. Brady, Sr. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Anita A. Chilcote (Daughter 1326 Cypress Street Baltimore, Maryland 21226 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, Stete Holy Cross Cemetery 7/30/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Kevin E. Ecker McCully-Polyniak Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Physician ATHEROSCLEROTIC CARDIO VASCULAR DISEASE Immediete Ceuse (Final disease or condition resulting in deeth) /Medical 20 YEARS Examiner Due to (or es e consequence of): YEARS Physician/Medical Examiner FIBRILLATION CHRONIC ATRIAL law requires that the death certificate be executed bunel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760. attanding physician for use as the burie CEREBROVASCULAK ACCIDENT YEARC that initieted events resulting in death) Lest Due to (or as e consequence of) P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed I Records, þ 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? page 2 al or Attending Physicien: The la s afterdeath. 9 Director: After this certificate hes ed in by the funeral director, page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 NA Division of Vital Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Shipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide the Hospital or and 24 hours after the Funeral Directory planets in particular in the control of 1Scriffying Phyeicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

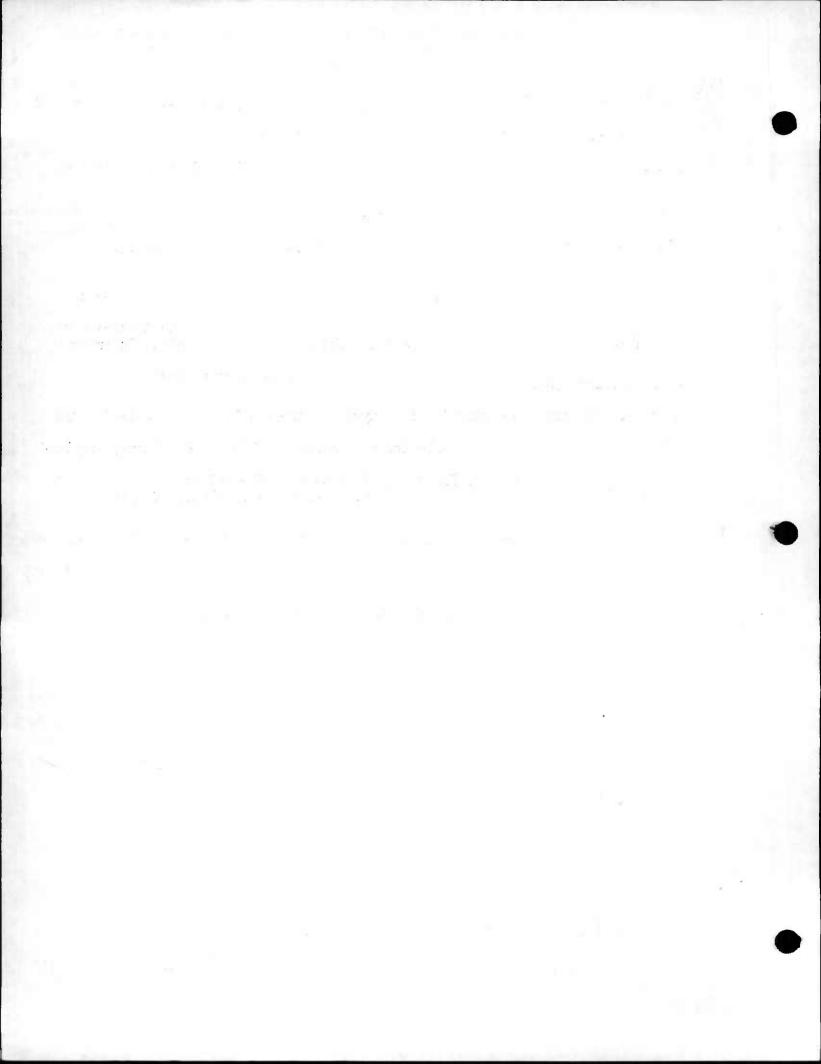
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29a. Certifier Medicai (Check only 29c. License number 29b. Signeture and title of confiler 29d. Date signed (Month, Dey, Year) KESIDENT A-12441614 JULY, 26 CENTER 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) HARBOR HOSPITAL S. HANDVER STREET, BALTINORE, SHARIF CHOWDHURY 3001 2/221 38. Registrar's Signeture

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

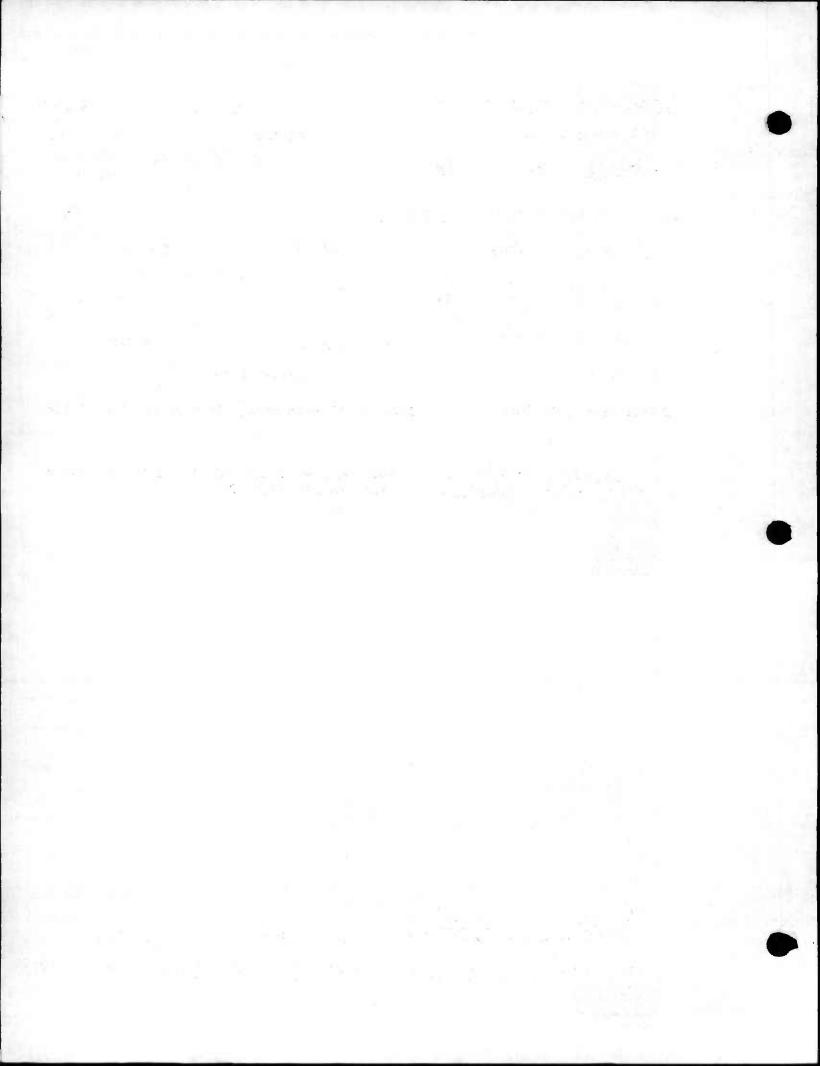


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Deeth **Physician** BARRY JEORGE E. July 18, 6:20 PM 1998 /Medical 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Death 2105 Homewood Avenue Baltimore Baltimore City If Under 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 8. Sax 7. Aga (In yrş. last birthday) Birthplace (Steta or Foraign Country) **Funeral** 219-01-2395 76 Months Hours Director Maryland Usual Rasidance of Decedant 10a. Stata 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be notified at MD Yas 2□No Director Baltimore City 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? 2105 HOMEWOOD U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 14. Raca - Amarican Indien, Biack, Whita, atc. 13. Wes Dacedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 □XYas 2 □ No If Yas, Giva Yaar or Detes: WWII 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: BLACK à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elamantary/Sacondary (0-12) Ship Yard Longshoreman 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Malden Surnama) Marie Sutton John Barry 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1908 Northbourne Road, Baltimore, Maryland 21239 George Barry, Jr./son 20b. Placa of Disposition (Nama of comatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☑ Donation 5 ☐ Other (Spacify) 21. Signature of Fune al Sarvice Licensee Wade Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Pet 1. Entar tha disease or complications that caused tha deeth. Do not antar tha mode of dying, such es cardiec or respiratory errest, shopk, or heart failure. List only one ceuse on each line. Approximate intarval Between Onsat and Death **Physician** immediata Causa (Final disease or condition resulting in death) /Medical years CANCER OF Examiner Dua to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed Sequentielly list conditions, if eny, laading to immediata causa. Entar Underlying Causa (Diseese or injury that initiated evants rasulting in daeth) Last Dua to (or as a consequance of): P.O. Box 68760, ician/Medicai Dua to (or es a consaguança of): Part il. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Physi 1 Yes 2 No 3 Probably 4 Unknown Records, OPI 24b. Were autopsy findings available prior to complation of causa of death? Completed 24e. Was an eutopsy performed? After this certificate has CONGESTIVE HEART FAILURE 1 Yas 2 No 1 □ Vas 2 □ No Division of Vital 25. Wes casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Spacify) 1 Yes 25 No Certification: To 28c. injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Phywithin 24 hours after death.
To the Funeral Director: After the completaly filled in by the funera 28b. Tima of 28d. Describe how Injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accidant 8 Could not be datamined 3 ☐ Suicida 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida TE Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D15462 30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print) 300E. 33rd St. BALTO, MD. 21218 KARACUSCHANSKY 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State the Davidson-Randell Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #19a Per Anatomy Board, 24a, b, Per MD Per KB Film G761 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Caleb Brown April 30, 1998 12:33 PM /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 502 Calvin Lane Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 11,1997 If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 19 Months 6 1⊠M 2□ F Yrs 213-51-9376 Maryland Director Usual Residenca of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde. permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryle Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show any Injury or other traumatic event, me Medical Examinat must be notified at ence. 1X Yes 2 □ No Maryland Montgomery Rockville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Calvin Lane 20851 United States Funeral 14. Raca - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Not Applicable Not Applicable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be Kenneth Brown Juliann Goldman 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) JULIANN Juliann Goldman/ Mother 502 Calvin Lane, Rockville, Maryland 20851
se of Disposition (Nama of Date 20c. Location - City or Town, State 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature Funesti Service Ligenson Wade, 22S Yanted Attato My Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Respiratory Arrest disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner Epstein's Anomaly of the heart physician end s the burial-transit requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dandy Walker brain malformation P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ettending p Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Bilateral glaucoma-repaired Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed pege 2 1XXYes 2□No 1XXYes 2□ No certificate Division of Vital Hospital or Attanding Physician: funeral director, Be 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ₹ No After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1XIXI Natural 5 Pending efter deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and makiner stated. (Check within 2 To the To the

State Registrar

29b. Sign

31. Date filed (Month, Day, Year) 291998

ddress of person v

Carol Ann Plotsky, M.D.

32. Registrar's Signature This Davidson-Randell

mpleted cause of death (Item

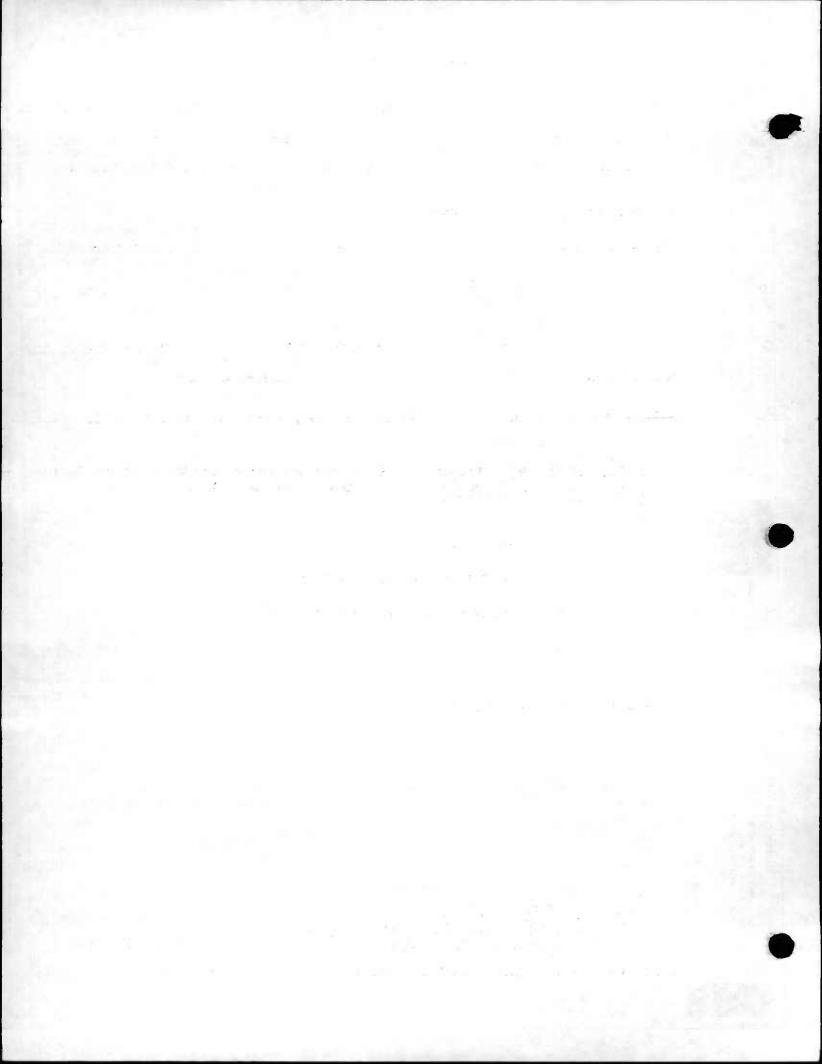
29c. License number

040592

1081 Darnestown Road, #103, N. Potomac, Maryland 20878

29d. Dele signed (Month, Dey, Yeer)

April 30, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death Month **Physician** RANIC 8:12 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, giva street and number) 4c. County of Death **Examiner** Liberty Medical Center Baltimore n/a If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days 15 M 2□ F 70 Yrs. 212-28-4216 Director Aug. 2, 1927 Md. Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Md. n/a Baltimore Directo 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours aftar death with Hygiane. other than "netural", or items 23a or 3714 Barrington Road 21215 USA Funeral 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No 11 Yes, Giva Year or Datas: 1 ☐ Never Married 🂢 Married Baltimore, Maryland 21215-0020 1 ☐ Yes & No Specify: Specify: Black þ 3 Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Mass Transit Elamantary/Secondary (0-12) College (1-4or 5+) MTA Driver Administration is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mantal Important: If item 27 is marked or Frank J. Barksdale Pearl B. Chase 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 3714 Barrington Road Baltimore, Md. 21215 Frances B. Barksdale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Arbutus Memorial Park July 30 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Nutter Funeral Homes, Inc. ry of Funeral Service Licens 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Part 1. Enter the disea shock, or heart failure Approximate Interval Batwaan Onset and Death Do not antar the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediata Causa (Final Millates EMBOCCUS DNAIZY disease or condition resulting in deeth) Examiner Examiner attending physician and for usa es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? been signed by table should be datach 1 Yes 2 No 3 Probably 4 Vunknown ymphone - (by - leg wan he Division of Vital Records, g 24b. Wara autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy HASCUT has 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No cartificata Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this cartifical letaly filled in by the funeral director. 25. Was case referred to medical example? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Othar: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 ENatural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as steted. edicai completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2 To the

Registrar

GREGORIO 31. Data filed (Month, Day, Year)

29b. Signeture end title of cartifier

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

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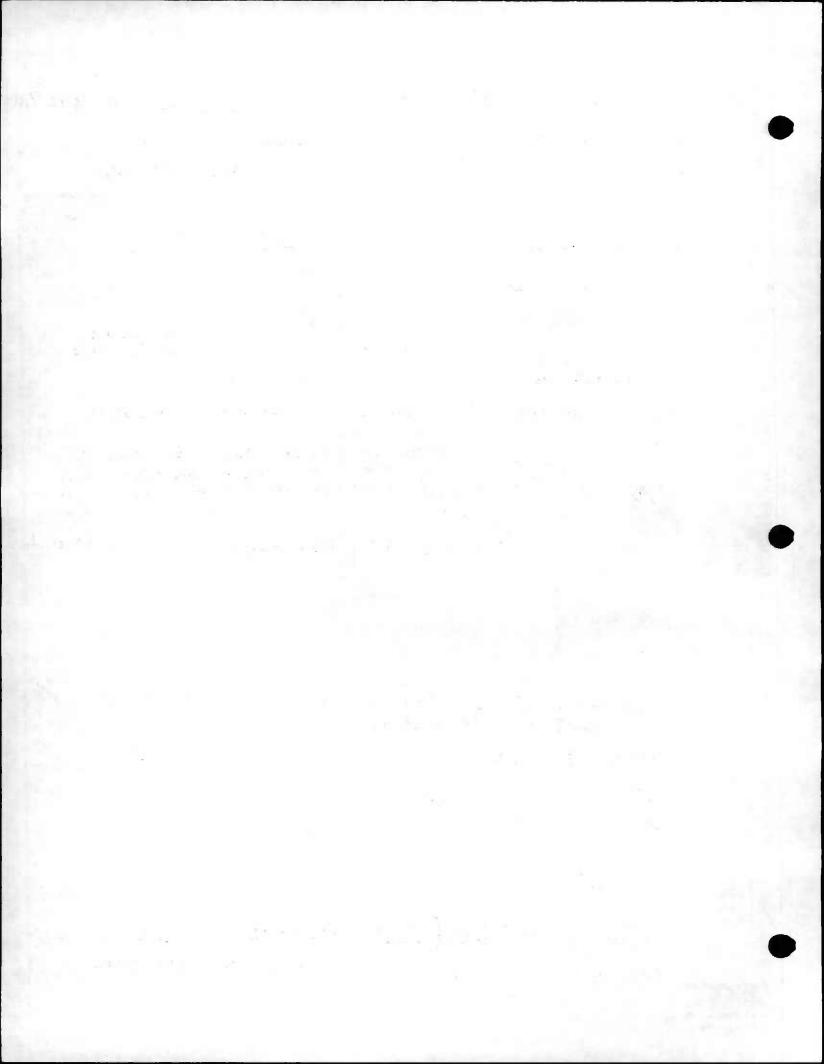
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29c. License number
20 48 26

29d. Date signed (Month, Dey, Year)

LibERTY MED. CENTETZ

32. Registrar's Signaturi Jundson-Randelle 291998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** 3:08 PM Bevert Margare 0 /Medical 4e Fecility Nama (If not institution, giva street end number 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Ba rimore 1405 1300 Secours
5. Social Security Number 6. Sax n/a If Undar 1 Yaar | If Under 24 Hrs. 7. Aga (In yrs. last birthdey) 8. Deta of Birth (Month, Day, Yaer) Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours 1 M 200 84 Yrs. 212-12-6201 Director June 29, 1914 Md. Usual Rasidence of Decedent with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Depertment of Health end Mentle Hydens. Important: If Item 27 is marked other than "natural; or items 23a or 23a-f show any injury or other traumatic event, it is Medical Examine man to northed. Md. n/a Baltimore No 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2302 W. Mosher Street 21216 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - Amaricen Indian, Black, Whita, atc. 12. Was Decedant Evar In U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas & No If Yas, Give Yaar or Datas: 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas XXNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maidan Sumama) Be Samuel Dorsey Elizabeth Holly 2 19a. Informent's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Muriel Beverly-Washington 14612 Knotley Road Silver Spring, Md. 20905 20b. Plece of Disposition (Nema of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ©Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata New Cathedral Cemetery July 28 Baltimore, Md. 4 ☐ Donetion 5 ☐ Othar (Spacify) 22. Name end Address of Facility Nutter Funeral Homes, 21. Signatura of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that cause in the disease, or heart failure. List only one cause on each full. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. 2501 Gwynns Falls PKWY Baltimore, Md. Approximata Intarvai Batween Onsat and Daeth Physician Immediate Causa (Finel disaese or condition resulting in daath) /Medical Examiner Dua to (or as a consaquanca of): Physician/Medical Examiner nema ettending physician and for use as the buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Diseasa or injury that Initiated avants rasulting in daath) Lest Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in tha undarlying ceusa givan in Part I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings evailabla prior to complation of ceusa of daath? 24a. Was an eutopsy performad? Completed this certificate hes No 1 □ Yes 2 □ No 1 Yes Lal or Attanding Physician: The offer death.

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In Director: After this certificated in by the funeral director, pa Be 25. Was cesa referred to medical 26. Placa of Daath (Chack only one) axaminer? Other: 4 Nursing Home 5 Rasidance 6 Othar (Spacify) 1 Yas 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Daath 28b. Tima of 28d. Describe how injury occurred 1 Natural 2 Accidant 5 Panding invastigation 1 Yas 2 No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral DI completely filled in Certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and place, end due to the ceuse(s) end menner es stated.

Medical Examiner: On tha basis of axeminetion end/or invastigetion, in my opinion, daath occurred et the tima, dete and place, and dua to tha ceusa(s) and mannar stated. edical 29a. Cartifiar 29b. Signatura and titla of certifier Pettikar 29d. Date signed (Month, Day, Year) 29c. Licansa number 50853

completed cause of deeth (Item 23e) (Type, Print)

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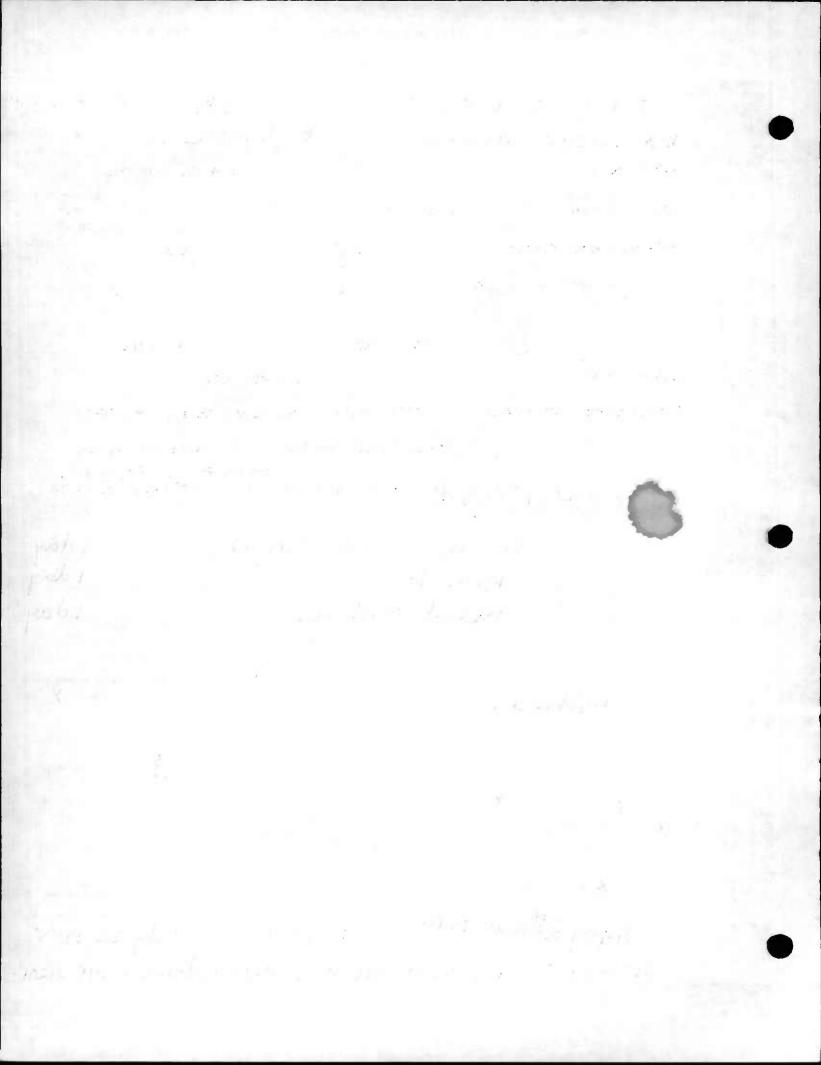
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N. Eutaw St. #407

Baltimore MD 21201

State Registrar 30. Nama and addrass

31. Data filad (Month, Day



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Dev Month **Physician** 26 1998 6:15AM Edna W Brown July /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Ellicott City 8104 Valley Lane If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours 1 M 2 F Yrs. 79 Sept 11 1918 Maryland Director 218-01-1354 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryla Department of Heelth and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmer must be notified at once. 1 ☐ Yes 2 No Directo Maryland | Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. 21043 8104 Valley Lane Funera 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Maritei Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Midowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Brown's Hotel Proprietor 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Margaret Monghan Alfred Wellmer 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8104 Valley Lane Ellicott City, Maryland 21043 Violet W. Macey / Sister 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 7/28/ 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removei from State Baltimore/Washington Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 1998 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signeture of Funeral Servica Licansee Reha 1630 Edmondson Ave Catonsville, MD 21228 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer feilure. Lift only one ceuse on each line. Approximete intervei Between Onset end Deeth Cervix = metastases **Physician** /Medical Immediate Cause (Final 10 ar disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner ettending physician end for use es the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? the bed Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No been signed by the should be detech 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed hes le 2 After this certificete he funeral director, page 1 TYes 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of Naturel 2 Accident 5 Pending s after dee... 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in 24 hour.
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> State Registrar

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31. Date filed (Month,

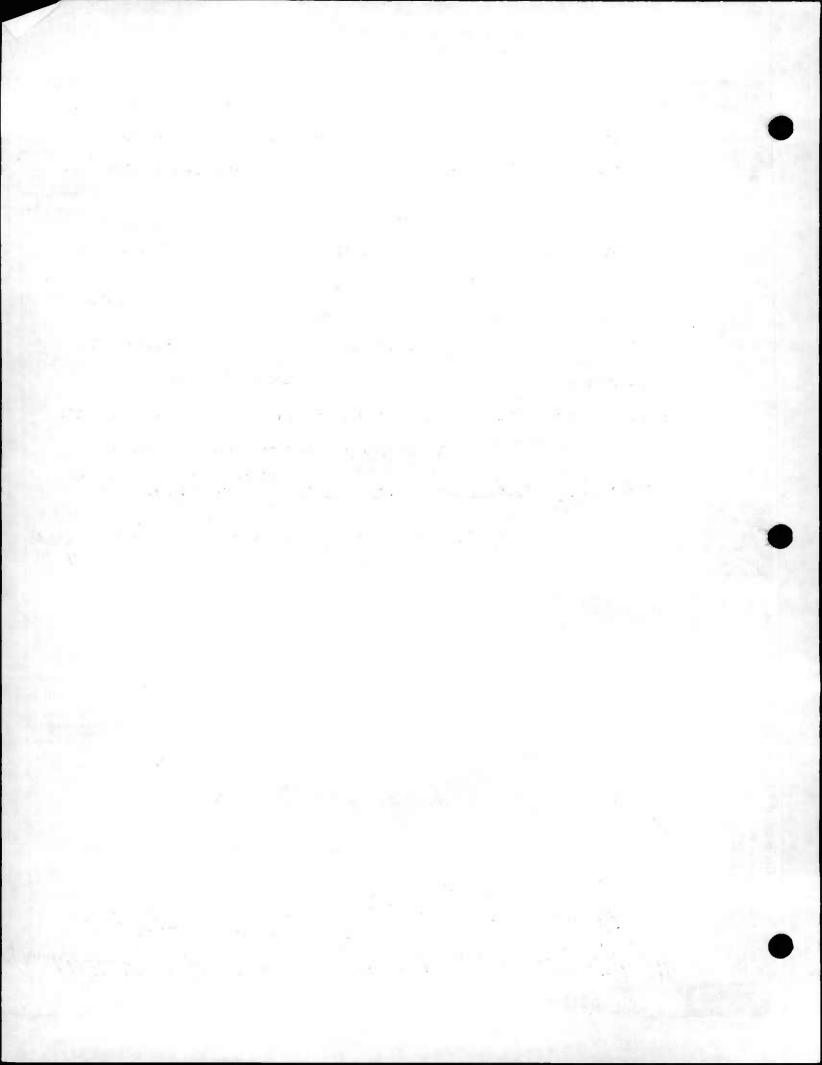
29a. Certifier (Check only one)

29b. Signeture en

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piace, and due to the ceuse(s) end menner as stated.

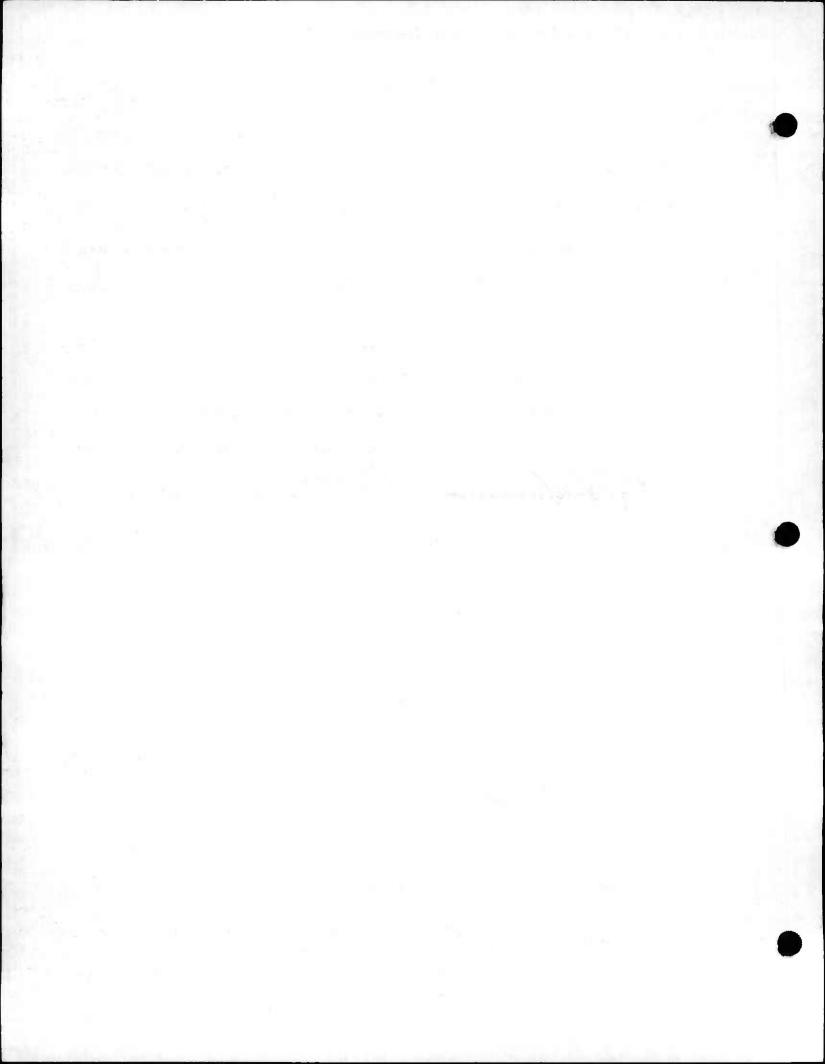
2 Medical Examiner: On the best of examination end/or layer ligation, in my opinion, death occurred et the time, dete end pieca, end due to the ceuse(s) and menner steted.

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Completed	3	15. Decedent's E	ducation	16	ia. Decedent's Usual Occ	cupetion	16	6b. Kind of Bus	siness/Industry										
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Be C		17. Fether's Neme (First, Middle, Las	t)			18. Mother's Name	e (First, Middle, Me	aiden Sumeme	1e)										
To	5	Ollie	James		Coleman	Norma	Rober	ta	Phillips										
		19a. Informent's Name/Relationship Brenda M. Colema:			9b. Mailing Address (Stre														
	-		ii / Sister		214 N. Silve	er court, i			21231										
5	1	20a. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 [4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	<i>ce</i> me	of Disposition (Neme of tery, cremetory or other p n Mount Crer				ore, MD										
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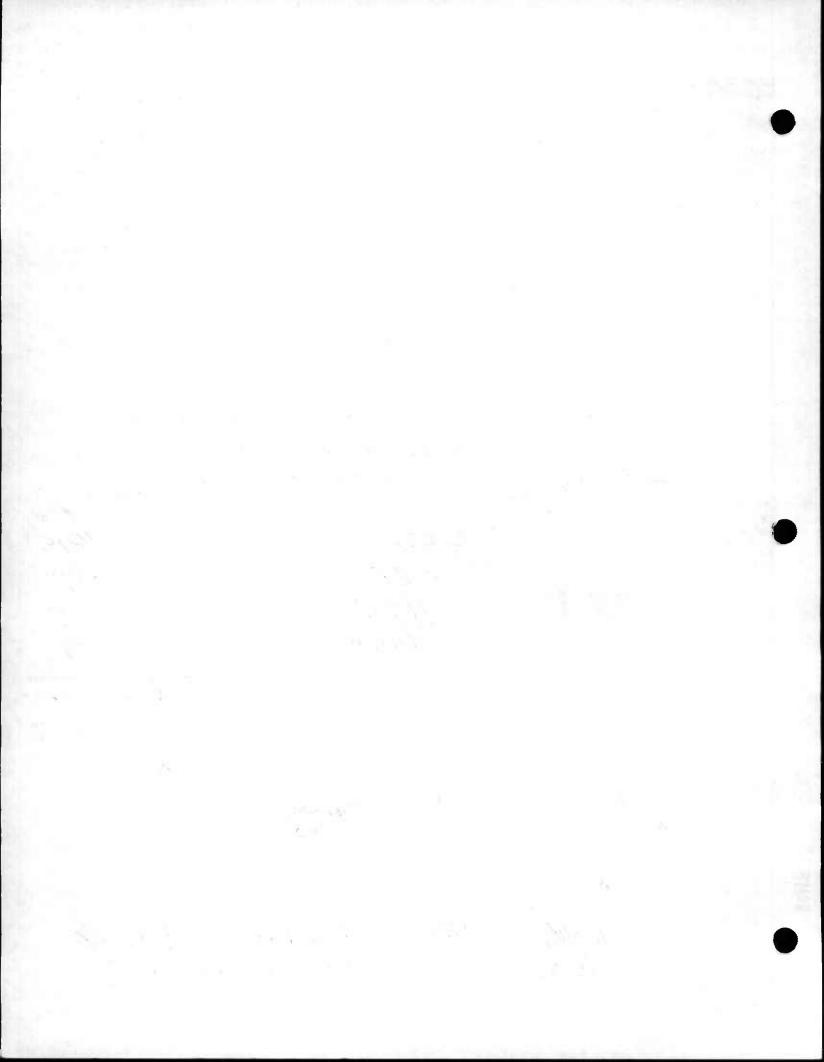
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 16:10 JUIGRA 26 /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City. Town, or Location of Daeth 4c. County of Deet Examiner citural MAR BALTEMORE If Under 24 Hrs. 8. Deta of Birth Houre Min. A P. M. Devis 5. Sociel Security Number If Under 1 Yaar 9. B tholace (Stete or Foreign 8 Sax 7. Age (in yrs. lest birthdey) **Funeral** Deys M 2□ F Months 97 1901 Yrs. Director 217-01-0014 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Hauth and Mentel Hygiana. Important: if Item 27 Ie marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, its Medical Expirites must be actified at 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits MD N/A BALTO Director 1 DXYes 2 □ No 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 1523 N. U.S.A. CAROLINE ST 21213 Funeral 14. Reca - American Indian, 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Merried Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: BLACK ð 3 X Widowed 4 Divorced Yeer or Detes Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Spacify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) LONGSHOREMAN PORT 5th N/A 17. Fether's Nema (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) Be 2 Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) BRENDA WILLIAMS/GRAND AUGHTER 1523 N. CAROLINE ST BALTO, MD 21213 Baltimore. 20b. Pieca of Disposition (Neme of cometary, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Steta ARBUTUS MEM PK 7-31-98 BALTO, MD 4 ☐ Donetion /5 ☐ Other (Specify) 21. Signetura of Funerei Sarvice Licansee. 22. Nama and Address of Fecilit BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 atrecia 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner depolation siclan and burial-transit certificata be axecuted Sequentially list conditions, If eny, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as e consequance of) Records, P.O. Box 68760. signed by tha attending physiclan d be datached for usa as the buria Physician/Medical Due to (or as a consequence of): Pert Ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 100 3 Probably 4 Unknown þ icata has been sign, paga 2 should b 24b. Were eutopsy findings evalleble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? Aftar this certificata has 20 10 1 Yas 2 No Division of Vital director, Be 25. Wee-casa referred to medical examinar? 26. Place of Deeth (Check only one) 28e. Dete et Injury (Month, Dey Year) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 Yas 2□ No 2 ☐ ER/Outpatient 3 ☐ DOA ner of Death
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State of Maryland / Department of Health and Mental Hygiene

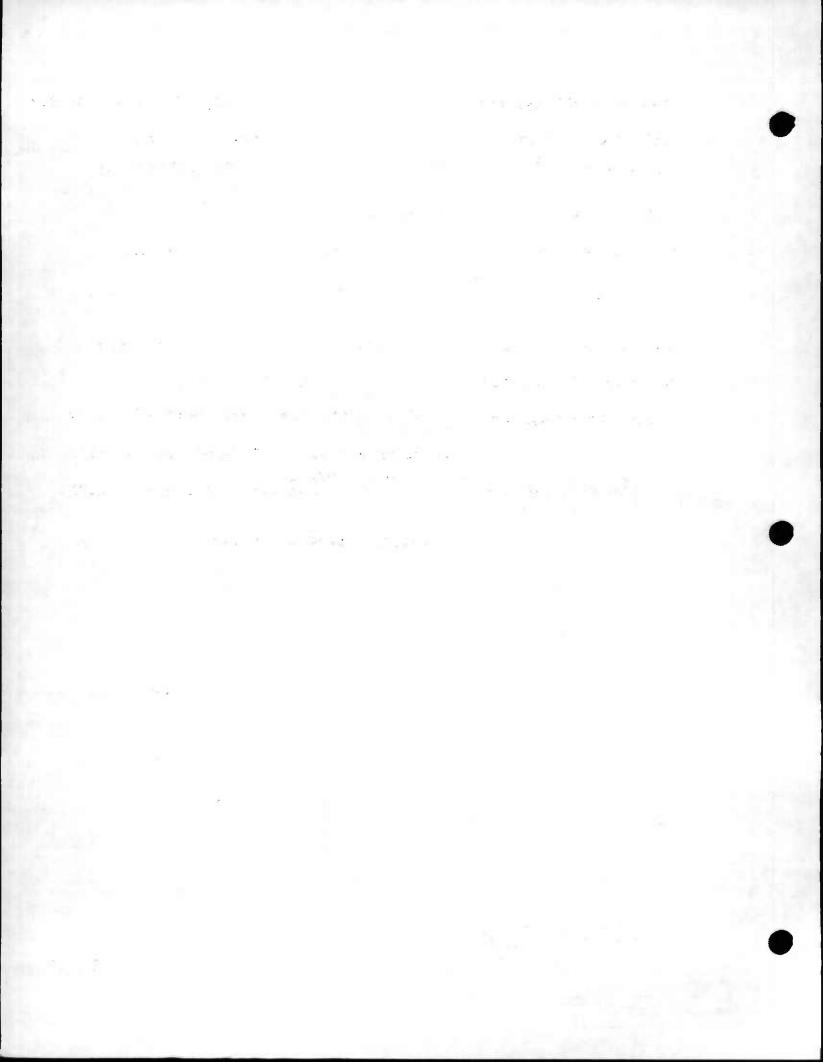
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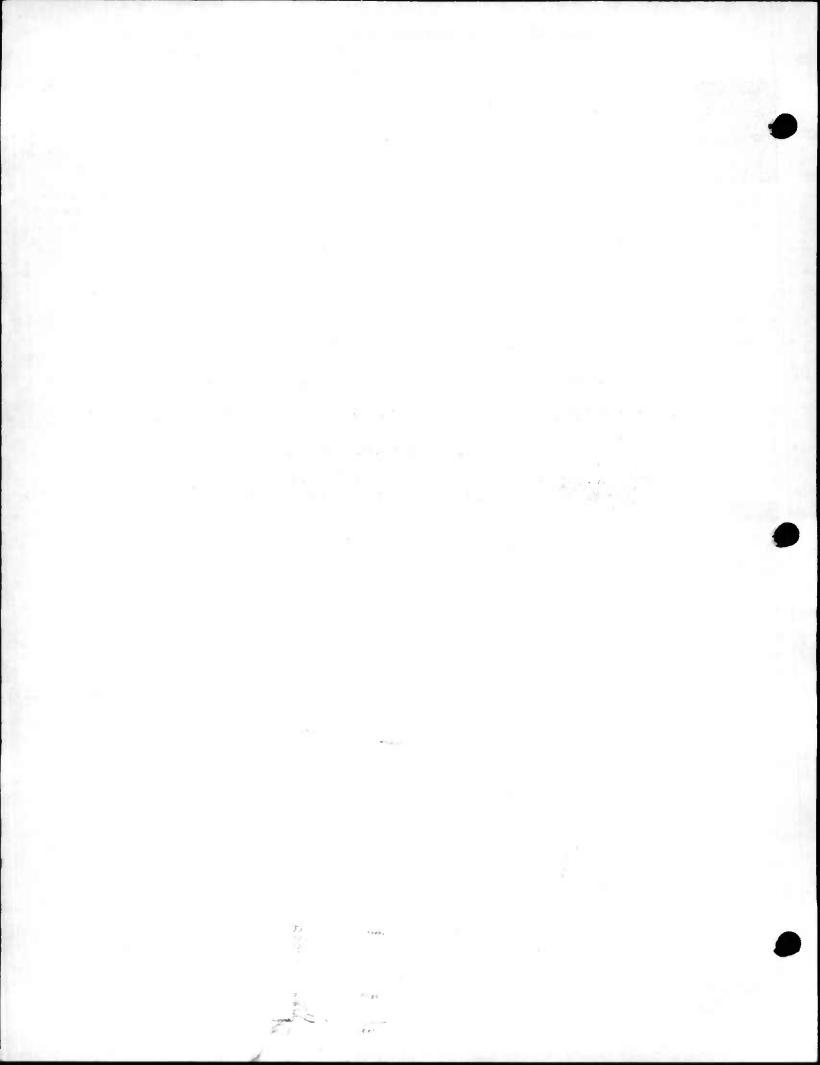
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Year **Physician** 22 1998 4:49pm Lawrence Clinkscales July /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Baltimore 4222 Eldone Road If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Yrs. **Director** 79 08 06 18 199-28-7987 NC Usuel Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or flores 23a or 28a-f show with Injury or other traumatic event, the Medical Examiner must be notified at antice. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Director MD NA Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21229 U.S.A. 4222 Eldone Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. þ 3 Widowed 4 Divorced Black Completed 16a Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Conductor Railroad na 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Lawrence Clinkscales Ethel Clinkscales 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4222 Eldone Road, Baltimore Md 21229 Brenda Lea-daughter
20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burlel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/29/98 Owings Mills, Md garrison Forest 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md OKA 21215 Approximete Intervel Between Onset end Death 233 Fart I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shoot, or heart tailure. List only one cause on each line. Physician Immediete Ceuse (Finel diseese or condition resulting in deeth) Irlustales /Medical mostate. Examiner Due to (or es e consequence of Examiner ettending physician end for use es the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as e consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were eutopsy tindings eveileble prior to completion of cause ot deeth? been si Completed 24e. Wes en eutopsy has e 2 page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete or Attending Physician: director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Neturel 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigetion Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after d 4 Homicide To the Rospital within 24 hours a To the Funeral D edical 29a. Certifier 😭 Certifying Physician: To the best ot my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Dete signed (Month, Dey, Yeer) 29b. Signeture end title of certifier 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) PURTE 11 JOHN HOPKIN BANIEN MEDILAL CANTER 4948 EAFER AVE BAN MAZIZZY MILHARL 31. Dete tiled (Month, Day, Year) 32. Hegistar's Signal uplant Registrar



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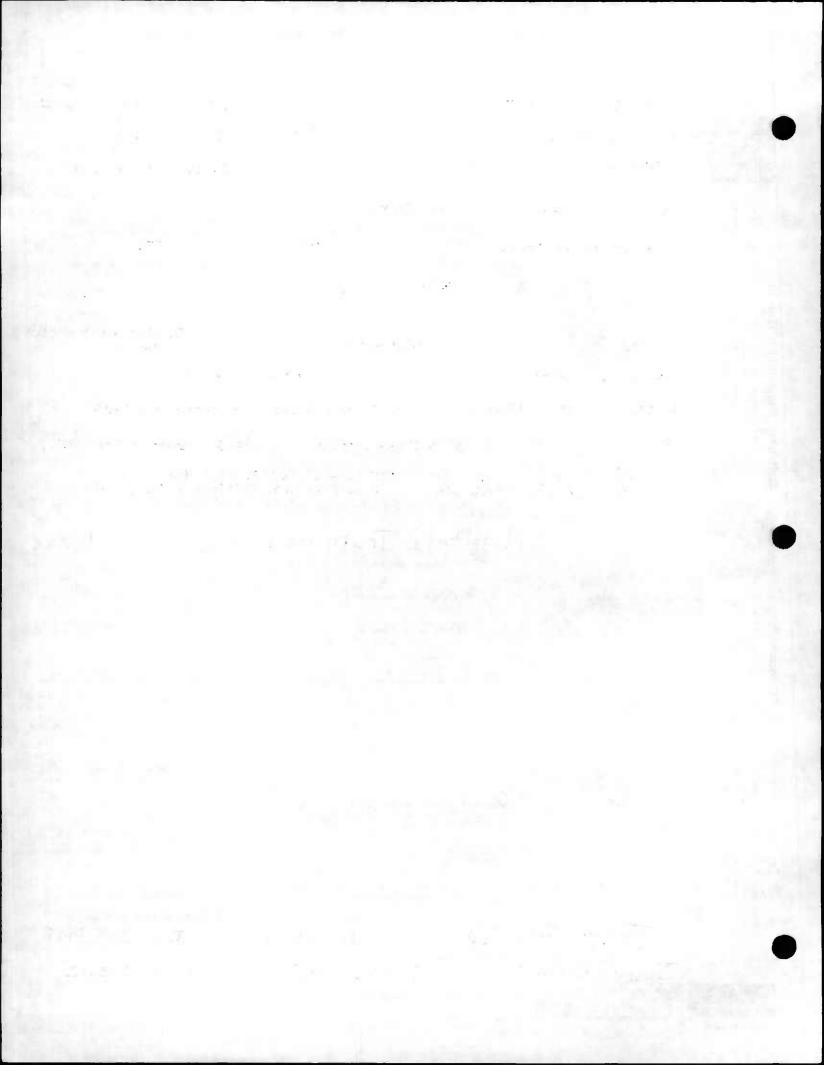
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					Certifica	ate of	Death		Reg. No.	0 2	3141	
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and and	-	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Tow	n or Location		-			1	Od. Inside City Limits	
Ba-f sh	Director	Md. n					1 Yas 2 No					
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	+	23a. Pert1. Enter the disease, or co	mplications that caused to									
Physician	И	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
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6		30. Nama and address of person wi	MM MD 3	201	T. PAU	LPL	ME I	BACTIMIN				
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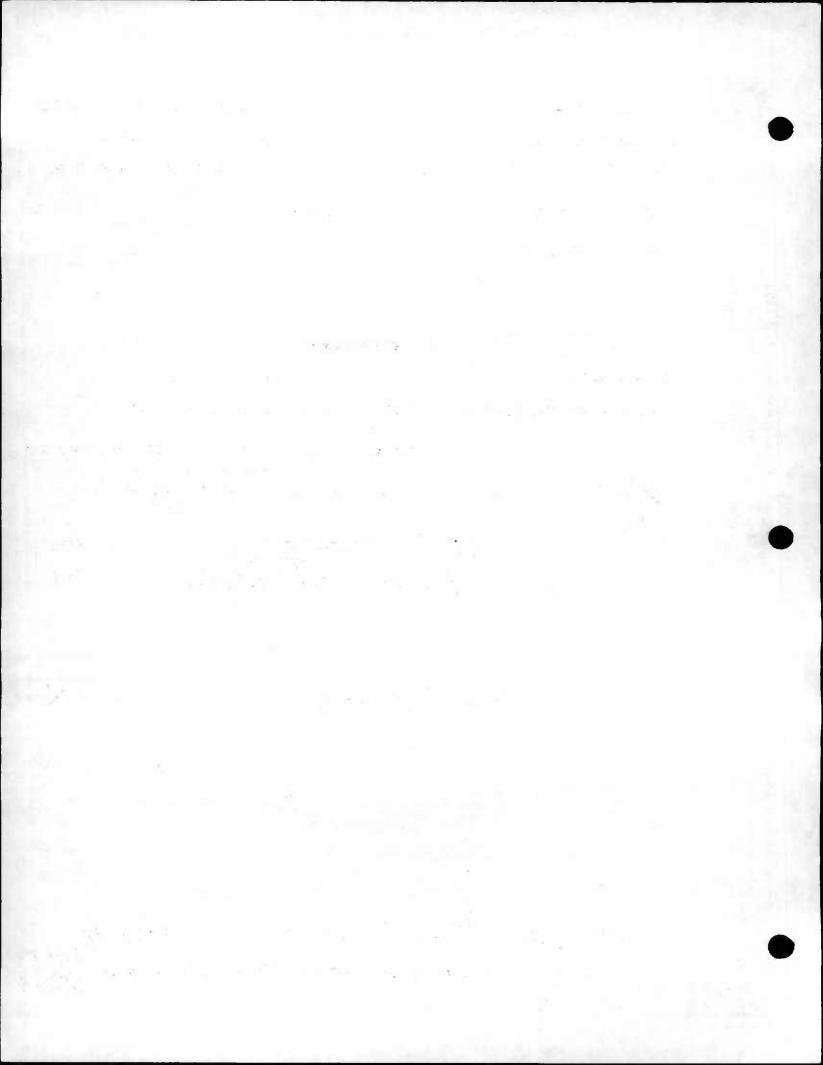


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | \(\infty Certificate of Death Reg. No. 2. Data of Death 3. Tima of Daath 1. Decedant's Nama (First, Middla, Last) Dey Month Year **Physician** July
4b. City, Town, or Location of Death 2:55PM Blanche Clarke 26 1998 /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Catonsyille ar If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 9/11/1906 Baltimore Genesis Elder Care If Undar 1 Year 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 5. Sociel Security Number **Funeral** Months Days 91 Yrs. 218-22-8987 WEST VIRGINIA Director Usual Rasidance of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Merylend Department of Health and Mental Hygiena. Important: If item 27 is marked other then "netural", or Items 23s or 28s-f show 10a. Stata 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yas 2 X No MD WORCHESTER BERLIN Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4620- C OCEAN PINES 21811 U.S.A. Funeral 12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yas 220 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Marital Status Navar Married 2 Married 1 ☐ Yas 2 ☐XNo Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) OWN HOME HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumame) Be THOMAS CLARKE BLANCHE (BURNETT) 2 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) MARY JOAN YEATMAN (NEICE) 4620- C OCEAN PINES BERLIN, MD 21811 Baltimore, 20b. Plece of Disposition (Name of camatary, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 6 7/28/98 BALTIMORE, MARYLAND DRUID RIDGE CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility 21. Signature of Funaral Sarvice Licansas WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228 mer 20 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Batwaen Onsat and Daath **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in daath) Examiner Examiner ettanding physicien and for use as the bunal-transit The law requires that the death certificate be executed Saquantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last as e consaguança of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaguanca of) signed by the et id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco usa contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably þ 24b. Wera autopsy findings availabla prior to completion of ceuse of death? should Completed 24a. Was an autopsy s certificata has t 1 Yas 1 ☐ Yas 2 ☐ No or Attanding Physician: After this certification and funeral director, i 25. Was casa rafarred to medical axaminar? Be 26. Place of Daath (Check only ona) Othar: 4 Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 5 Panding Investigation 1 Yas 2 No eftar death. 2 Accidant Director: 6 Could not be 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata) 3 Suicida 28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homicida filled in • Funeral C 29a. Cartifian Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and dua to the ceuse(s) end menner es steted. edicai 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) (Check only one) and mannar stated. within 2 29c. Licansa number 29d. Date signed (Month, Day, Year) rson who completed cause of deeth (Item 23a) (Type, Print) 30. Name and eddrass of pe JRAKH 32. Registrar's Signatura -- 1009 FREDERICK 31. Deta filed (Month, Day, Year)

JUL 291998 State his Davidson JUL

Registrar



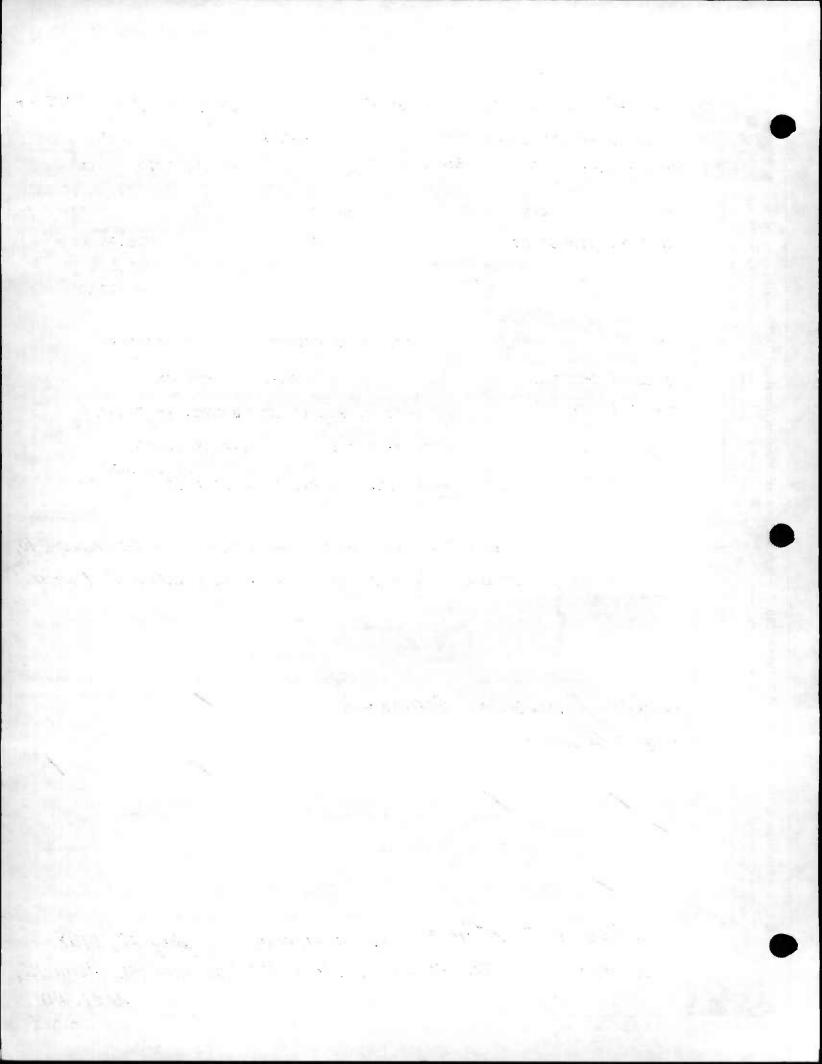
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Daath 3. Time of Death Month **Physician** July JAMES 1998 17:30 , LINWOOD DOUGLAS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva straat and number) Examiner UNION MEMORIAL HOSPITAL BALTO N/A If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar)

UL 11, 1922 7. Age (In yrs. last birthday) 76 Yrs. Birthplace (Stete or Foreign Country)
 VA 5. Social Security Number **Funeral** Months Days 1 M 2 □ F Director 229-34-2561 Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. fnside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Expinier must be notified at 1 Yes 2 No Directo MD N/A BALTO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1607 E. BIDDLE ST 21213 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours effer Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or its any injury or other traumatic event, the Medical Examina 1 Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complatad) 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7th College (1-4or 5+) HOME IMPROVEMENT REALITY CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meidan Sumema) Be OUINTIN DOUGLAS BESSIE UNKNOWN P 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) NORMA DOUGLAS 1607 E. BIDDLE ST BALTO, MD 21213 20b. Place of Disposition (Nama of cematary, cramatory or other place, 20a. Method of Disposition 20c, Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEM PK 8-4-98 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility BETTS FUNERAL HOME 21. Signature de Filinarai Sarvice Licensee 1129 N. CAROLINE ST BALTO, MD 21213 100 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical fmmediate Cause (Final RESISTANT STAPHYLOCOCCUS AUREUS PREMIONIA 10 a Methicillin disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner CELL SQUAMOUS CELL CARCINOMA b. LEFT LUNG SPINCLE physician end s the burial-tren Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): USB BS 10 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 12 Yes 2 No 3 Probably 4 Unknown Vascular Oneas þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy pertensio 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) INO 2 ER/Outpetient 3 DOA 1 ☐ Yes Inpatient Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. fnjury at Work? 5 Pending investigation Natural 2 ☐ Accident efter death. Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) ne Hospital or Attendant 24 hours efter de Funeral Directo bletely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) JUMON July 27, 1998 HOSPITAL, BALTINGE, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL EDWARD 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

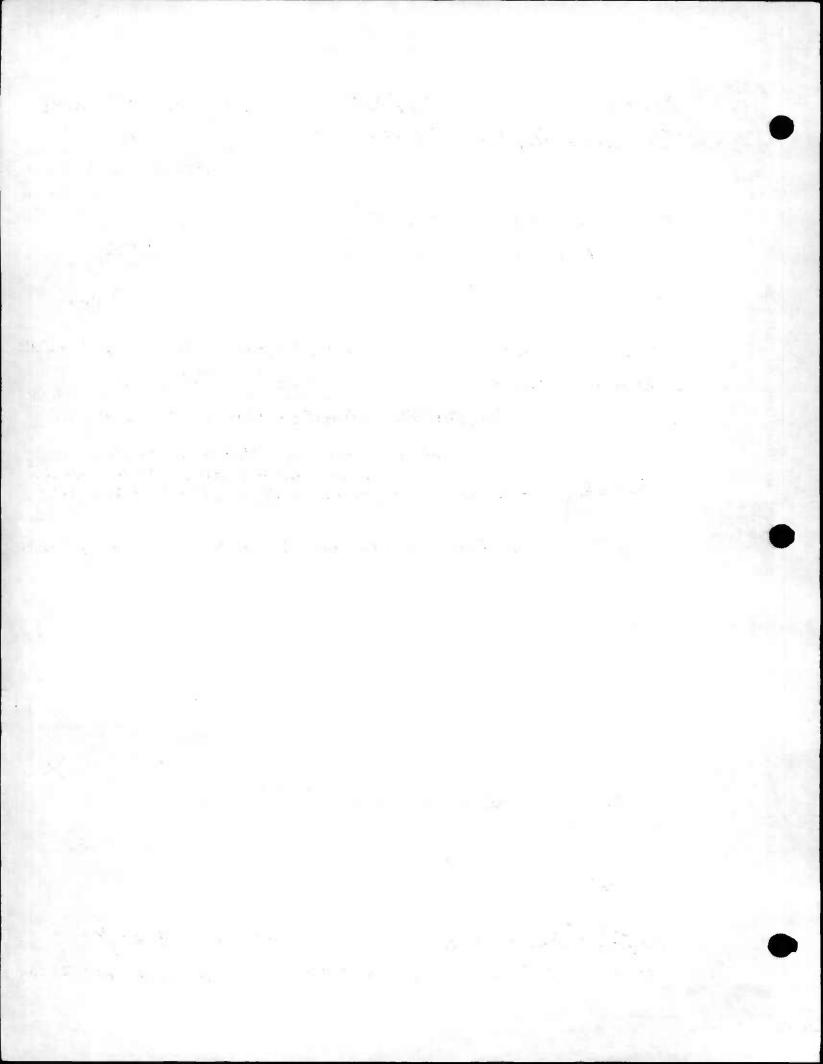
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Daath 3. Time of Death 1. Dagedant's Name (First, Middle, Last) Month **Physician** 414 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner The Sohns
5. Social Security Number BAHIMORE
If Under 24 Hrs. 8. Date
Hours Min. (Mor HOSPITZ Hopkins 8. Date of Birth (Month, Day, 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1□M 2XF 220-38-9082 Usuel Residence of Decadent Director Pages 1 and 2 should be filed within 72 hours after death with the Menyland neat of Health and Mental Hyglens. In this if left man 27 is merked other than "natural", or items 23e or 28e-f show lary or other traumatic event, the Medical Exerciper man be notified at any or other traumatic event, the Medical Exerciper man be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director OWARC Olumbia 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 21044 11225-13 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) The LOVE DEST 17. Father's Name (First, Middle, Last) Be WILLIAMS DEARIEY 2 UCILE JOHNSON 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 21207 daughter FRANKlin MUE, Apt 2-C 5918 Balto Eltou-ISA 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 20a, Method of Disposition permit. Pages i Department of F Important: if iten any injury or ott phose. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory Baltimore, MD 7/28/98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address HARCH FUNERAL Home West In la wm. AUE, BAITO WADASh 4300 0 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or haart failura. List only one cause on each line. Approximata Interval Between Onset end Death Physician Immediata Causa (Finei disease or condition rasulting in daath) /Medical Metastatic lung - small cell cancer Examiner Due to (or as a consequenca of): Examiner physician end s the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Cause (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of) 98 attending p signed by the a Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? should l Completed 24a. Was an autopsy certificata has b 2 2 No 1 Yes 1 Yes Division of Vital iclan: director, 25. Wes casa referred to medical examiner? Be 26. Piaca of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of Certification: 28c. Injury at Work? After 1 Attending 1 Natural 5 Pending daath 1 Yas 2 No invastigation 2 Accidant Director: n 24 hours after das ne Funeral Director nistely filled in by th 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

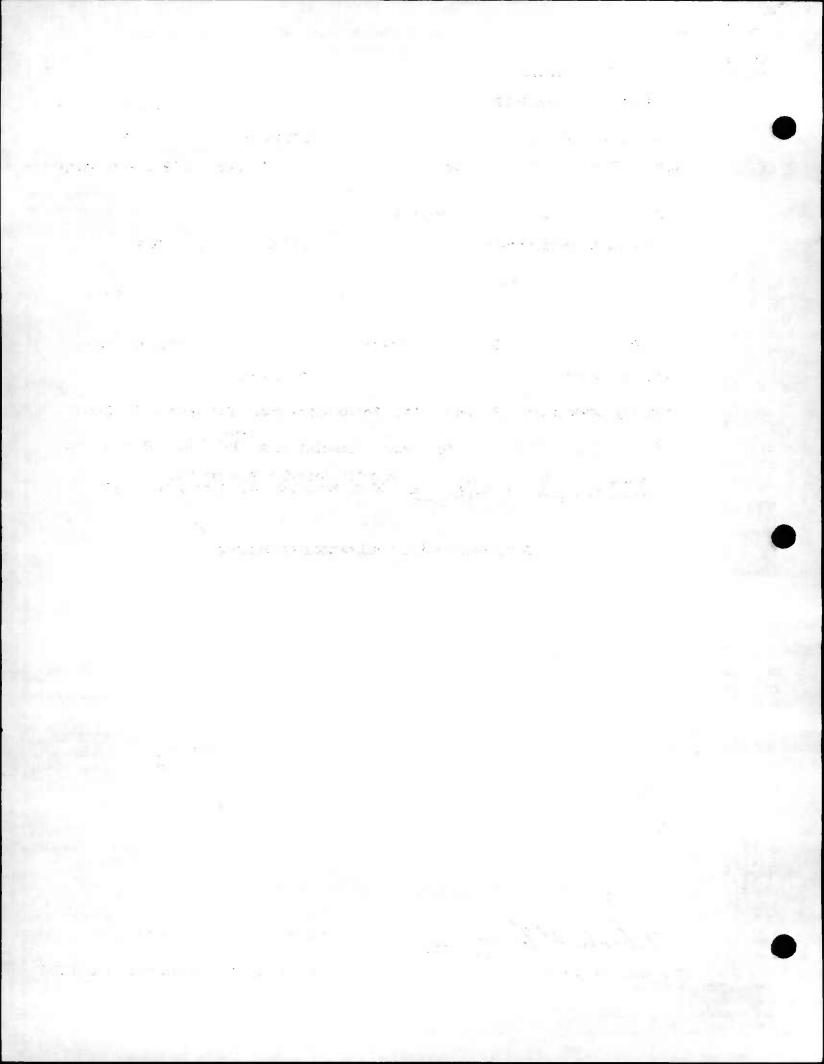
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of contline 29c. License number 29d. Date signed (Month, Day, Year) ne 30. Name end eddress of person who completed cause of deeth (Itam 23a) (Type, Print) LISA LOCKERN RUTZAND AVE BALTIMORE MD Z1205 720 MD 32. Registrar's Signature 1.02 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

EUGENE DUGGER	It	tem: 12 per F.	.H. G-761	State of N 2/29/98 re			artment rtificate			d Mei		ene 9 8	2	31	45
		1. Decedent's Name (F	First, Middle, La		1	by I				2.	Dete of Deeth Month	Dev	Year	3. Tin	ne of Deeth
Physicia */Medic		EUGENE	L. DU	GGER, SR.						J	JULY		998	5:	45P.M.
Examin		4a Fecility Neme (If no	ot institution, giv	e street end numbe	r)			4	b. City, Town,	or Locat	ion of Deeth	4c. County	of Deeth		
		1748 S.HA	NOVER S	TREET					BALTIM			1	/a		
Funeral Director		5. Social Security Number 218-36-673	30	Sex 7. A IDXM 2□ F	Age (In yrs. 58	lest birthdey) Yrs.	Months	1 Year Deys	If Under 24 i	Hrs. 8. Min.	Dete of Birth (Month, Day, 1eb 25	^{Year)} 1940	9. Birthr Cour West	Vir	ate or Foreign ginia
pu .		Usuel Residence of De 10a. Stete 10	b. County		10c Cit	y, Town or Lo	cation						1	Od Ineid	le City Limits
Marylen f show	ō	Md.		n/a		altimo									Yes 2□No
with the M a or 28a-f	Funeral Director	10e. Street end Numbe	er	r Street			10f. Zip	Code	21230)	10	g. Citizen of USA		ntry?	
eath w	era	11. Marital Status		12. Was Deceder	nt Ever in U	S. 13	Was Deced	ent of H			v Yes or No-		e - Americ	an Indie	n.
21215-0020 d within 72 hours effer death with the Maryland gjene. r than "natural", or items 23a or 28a-f show it the Modical Examiner must be notified at	by Fun	1 Never Married	4.6	Armed Forces 1	XNo		if Yes, spec 1 ☐ Yes 2		ispanic Origini n, Mexican, Pi Specify:	uerto Ric	an, etc.)		ck, White,	etc.	
15-00 72 hours "netural",			. Decedent's E			16e. Dece	dent's Usue	Occup	etion		_ 1	6b. Kind of B	usiness/in	dustry	
within 7 ene.	Completed	(Specify description (Specify description)	only highest gra	completed) College (1-4o	5+)	(Give	kind of wor DO NOT us	rk done d se retired	during most of	working					
212 od with giene.	5	10	, (, , , ,	0		cut	ter					Printi	ng Pi	cess	
ire, Maryland 21215-0 s 1 and 2 should be filed within 72 ho Health and Mental Hygiene. Hem 27 Is marked other than "netur other traumatic event, the Medical	To Be	17. Fether's Name (Fire Alston Da)					18. Mother's Opal		First, Middle, M	laiden Sumer	ne)		
e, Mary 1 end 2 sho Health end P Health end P Health end P		19a. Informent's Name Shirley (ter)						loute Number, Baltim				
		20e. Method of Disposi			0	Pleca of Dispo	sition (Nen	ne of ther plac	e)	Ju	Pete 24 2	Oc. Location	- City or To	own, Stel	е
Pege Pege nent int: if		1 LXBuriel 2 □ C 4 □ Donetion 5 [Removel from Stat y)	° G1	en Hav	ren Me	emor	ial Par	rk 19	98 G	len Bu	rnie	, Md	•
Baltimore, pemit. Peges 1 e Department of Her Important: if item any Injury or othe		21. Signature of Funer	rel Servica Licer	Soo Di	۸۸۰	2: M	Name en ICCull	d Addres	ss of Fecility Olyniak	Fur	neral H	ome Md	21230)	
Maria Salah	-	23a. Pert1. Enter the c	diseese, or com	plications that cause	ed the de								21250	Approx	imate
Physician		23a. Pert1. Enter the of shock, or heart fa	ilure. List only	one ceuse on each	line.				•					interve	Between and Death
/Medical Examiner		Immediate Ceuse (Findiseese or condition resulting in death)	el	Arterio		otic (ovas	cular I	Disea	ase				
bel ist	Examiner			b											
.O. Box 68760, the death certificate be executed by the ettending physician and sched for use es the burial-trensit	xar	Sequentially list condit if eny, leading to imme	ions, idiate		Due to (o	er es a consec	quence of):								
8760, sete be exphysician the burial		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southlist is death.) Leaf													
ficet ficet	ed	resulting in deeth) Lest			Due to (o	r es e consec	juence oi):								
Box 68 leath certifice ettending ph	2		-	d			-								
d for d for	icia	Pert II. Other significar	nt conditions o	contribution to death	but not resi	ulting in the u	nderlylna c	ausa niv	en in Pert I		23h Did tol	acco use co	ntribute t	o the ca	usa of death?
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aw requisite to the second sec	Completed									_	INSPEC		00	mpletion deeth?	of cause
C 6 2 2	E										1□ Ye		1	Yes	2 No
Vital I	0	25. Wes case referred	to medical						28. Plece of	Death (0	Check only one	9)			
	0	exeminer? 1 X Yes 2 □ No		Hospitel:	tient 2	ER/Outpaties	nt 3 DO	A Oth	or.		5 Reside		ner (Speci	fv)	
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Vision Attending Actor: After Sctor: After	atio	1 Netural 5 2 ☐ Accident	Pending investigation		ey rear)	Injury	М		Yes 2 No						
Division or Attending after deeth. Director: Atte	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, st building, etc. (Specify)						, office		28f	Location (Str City or Town,		ber or Run	el Route	Number,
Red Services	edical			nysician: To the bes niner: On the besis end manner:	of examina										use(s)
To the	Me	29b. Signeture end title	of certifier				290	. Licens	e number		29	d. Date signe	ed (Month,	Day, Ye	ar)
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+		30. Name end eddress			death (Item	23e) (Type,		Don	n Ct-	ot I	Baltimo	mo M-	ים [יצינו	C For	1201
0:		Theodore K 31. Dete filed (Month, I			trar's Signe	ature		ren	n stree	et, l	рат стік	TE, PK	тула	ILI Z	1401
Sta	е	The state of the s	0.0404	OZ TROGIS	- David	1-1- Pano	delle								



Attending Physician: After this funeral

Certification:

27. Manner of Death 1 Naturel

28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of Injury

5 Pending investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 ☐ Homicide

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, State) Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

RUMD

29b. Signeture and title of certifie

29a, Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Yaar)

MD

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print) ROTHKIN MILLIAEL

31. Dete filed (Month, Day, Year)

291998



State Registrar

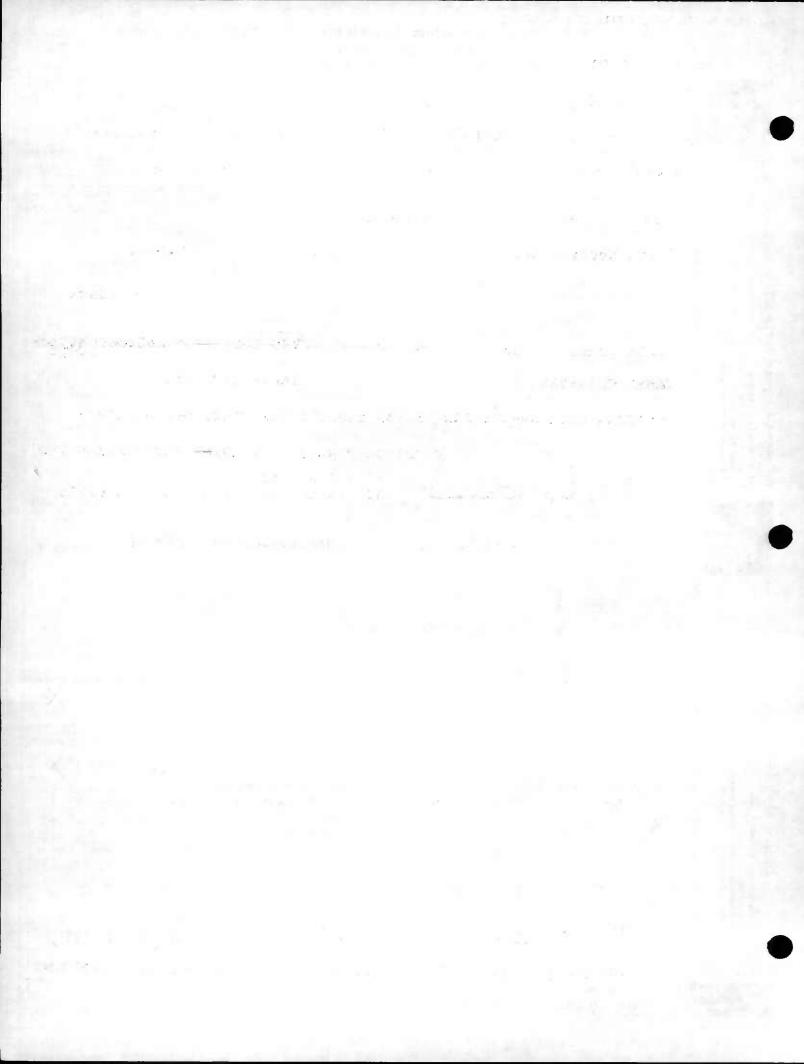
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DHMH 16 Rev 6/95

Hospital or A 24 hours after Funeral Direc

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To the Complete

RANDALISTON MARYLAND



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2120 DORIS ' /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SAUTI TORE MOSPIAR FREG If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F Months Yrs 220-22-115-70 4-23-28 Maryland Director Usual Residenca of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Ballemore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1403 DIVE STREET. 21230 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white PV 3⊠Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Line Stapler Meados Inc. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Schuhte Jessie Detress 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Quail Street Baltimore, Md. 21224 19a. Informant's Name/Relationship (Type, Print) (Daughter) Helen E. Hogan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 20c. Location - City or Town, State 28 DO Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 1998 Brooklyn Park, Md. 4 Donation 5 Other (Specify) 22. Name end Address of Fecility McCully-Polyniak Funeral Home 21. Signeture of Funeral Service Licenses 21230 130 E. Fort Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Juna CEREBRAL Hemorrhage Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy Completed 1 Yes 25 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

physician and s the burial-transit The law requires that the death certificate be axecuted Records, P.O. Box 68760. USB as been signed by the s should be datached has After this cartificate funeral director, pag Division of Vital Attending Physician: After this death, To the Hopfiel or Attendit within 24 hours after death.
To the Percent Director: A completely filled in by the fi

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death

Item 27 is marked other than "natural", or items 23s or 25s-1 show other traumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examina.

Saltimore, Maryland 21215-0020

Medical

State Registrar

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartiflet 3

30. Name and address opperson who completed cause of death (Item 23a) (Type, Print)

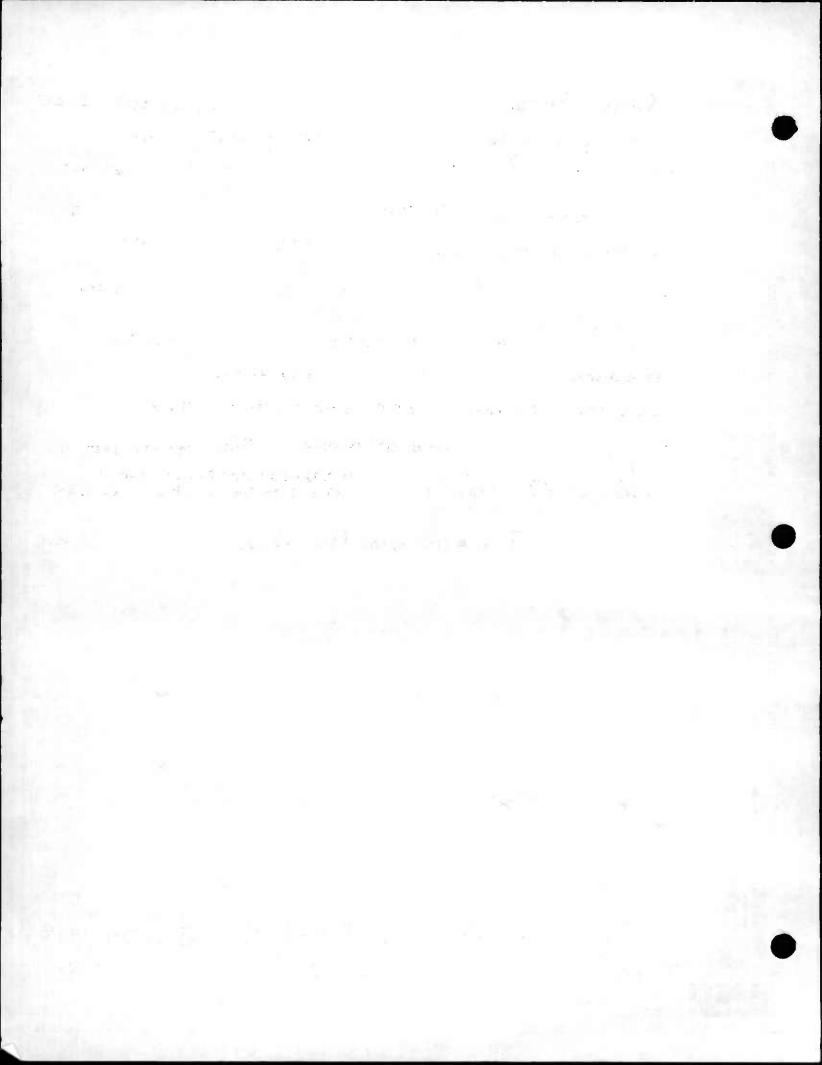
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31. Date filed (Month, Day, Year)
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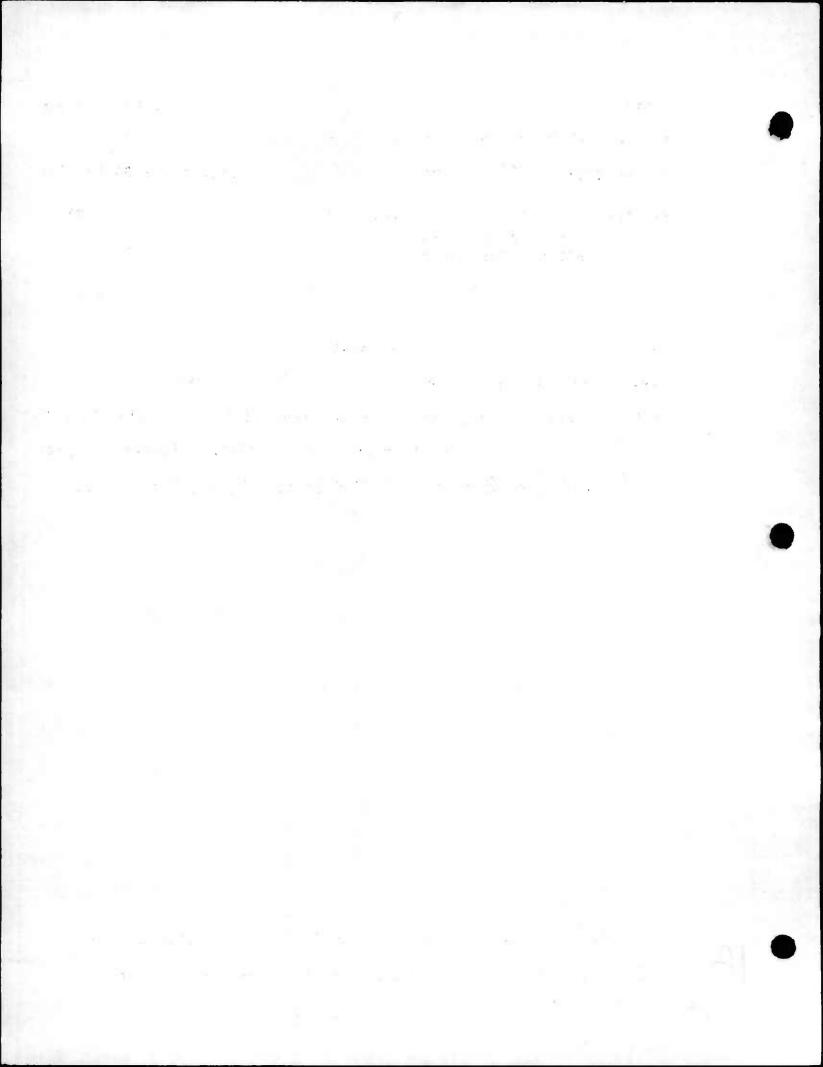
301 ST. PAUL PLACE

32. Addistrar's SignatureLaco



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician (Medical Examiner) Sarah Fisher As Facility Neme (If not institution, give street and number) Roland Park Place Health Care Center Roland Park Place Health Care Sociel Security Number 216-46-2307 Jusual Rasidence of Discodent 100. County Maryland N/A Baltimore 102. City, Town, or Localion of Deelh Roland Park Place 216-46-2307 Jusual Rasidence of Discodent 100. County Maryland N/A Baltimore 102. City, Town or Localion Oct. 14, 1906 Marylan Oct. 14, 1906 Marylan 103. Street and Number Roland Park Place 830 W. 40th Street 11. Maritel Status 12. Was Decodent Street in U.S. 13. Was Decodent Street in U.S. 14. Race - American Indien. 15. Decodent Street in U.S. 16. Decodent Street in U.S. 17. Septify: White 19. Decoder Street in U.S. 19. Decodent Street in U.S. 19. Decodent Street in U.S. 19. Decoder Street in U.S. 10. Was Decodent Street in U.S. 11. Maritel Status 12. Name and Address of Facility 19. Maintage Address of Facility 19. North Street in Address of Facility 19. North Street in Address of Facility 19. North Street in Address of Facility 19. Decoder Street in Address of Facility 19. Decoder Street in Address of Fac					Cei	rtificate of		Re	g. No.	3 23	148
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 1998 Month **Physician** Zle, 6 COLEMAN FIELDS /Medical 4b City, Town, or Location of Death 4c. County of Deeth Fecility Neme (If not institution, give street end number) Examiner IMORE 14 DME RSINO If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) 5. Social Security Number **Funeral** Deys na Months 1 3M 2 F 212-09-5504 Director Usuet Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: If then 72 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Menter at the must be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Saltimore 1 XYes 2 No **Funeral Directo** N 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21215 0SA 4206 12 Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced lac Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Service Elementary/Secondery (0-12) Coltege (1-4or 5+) Automotive Centu NA 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Mary CORDIN 2 ONN -CE 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 420 (W. KOARE TVE. Balto. Md) 4206 W. Jalto. Wite DUISE 00 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) DRUID RUGGE (CA) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 8P0E 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name end Address of Fecility re of Funeral Service Licenses WEST FUC WmC. Nerral Home jard 4300 Wabash Ave Tarre 23a. Pent. Enter the in ease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart in line. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finat disease or condition resulting in deeth) /Medical me month Examiner Due to (or as e consequence of) Examiner 6. Pila tros The law requires that the death certificate be executed attending physician end for use es the bunel-tran Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed' als certificate has but director, page 2 s 2 No 1 ☐ Yes 1 □ Yes 2 □ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Fundral prector: After this certifical completely infecting the funeral director, 86 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Dey Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Neturel Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde 29a, Certifier 1🗹 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and tin 29d. Date signed (Month, Dey, Year) 29c. License number

inpleted cause of deeth (Item 23e) (Type, Print)

182, Registrar's Signature Mandale

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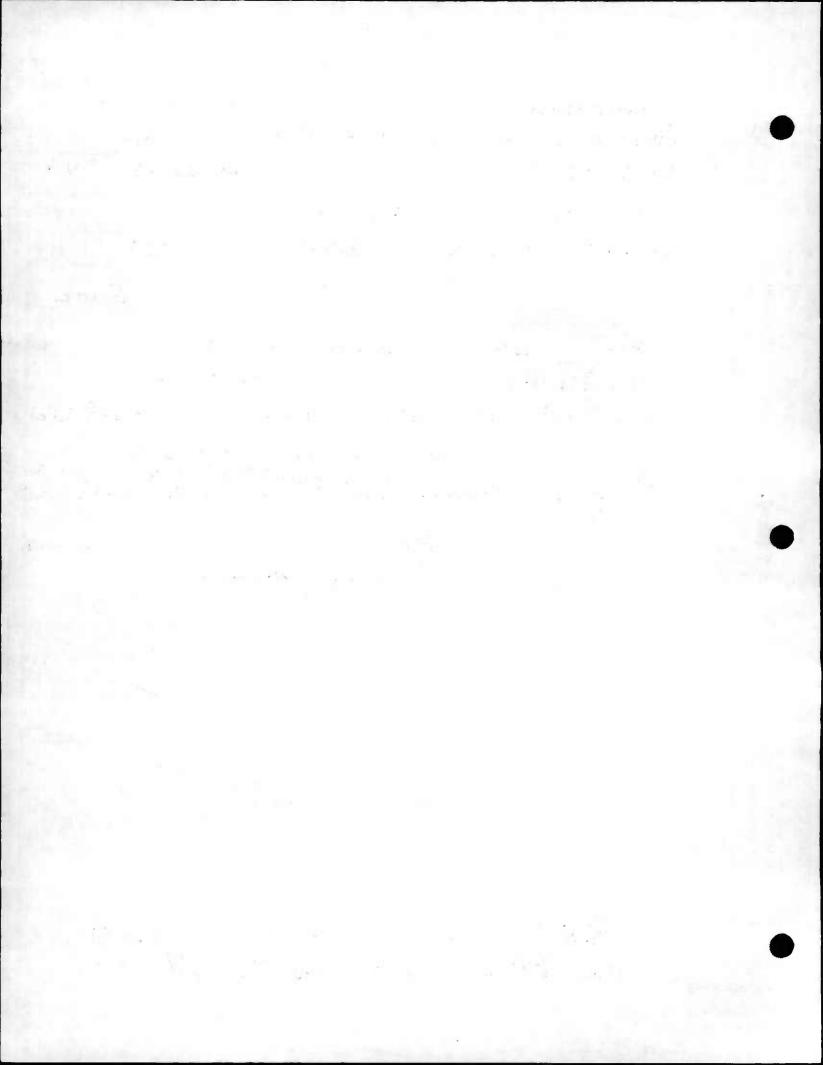
State

Registrar

30. Name and add

31. Dete fited (Month, Dey, Year)

un



Records, P.O. Box 68760, sion of Vital

State

29b. Signature and tipe of certific

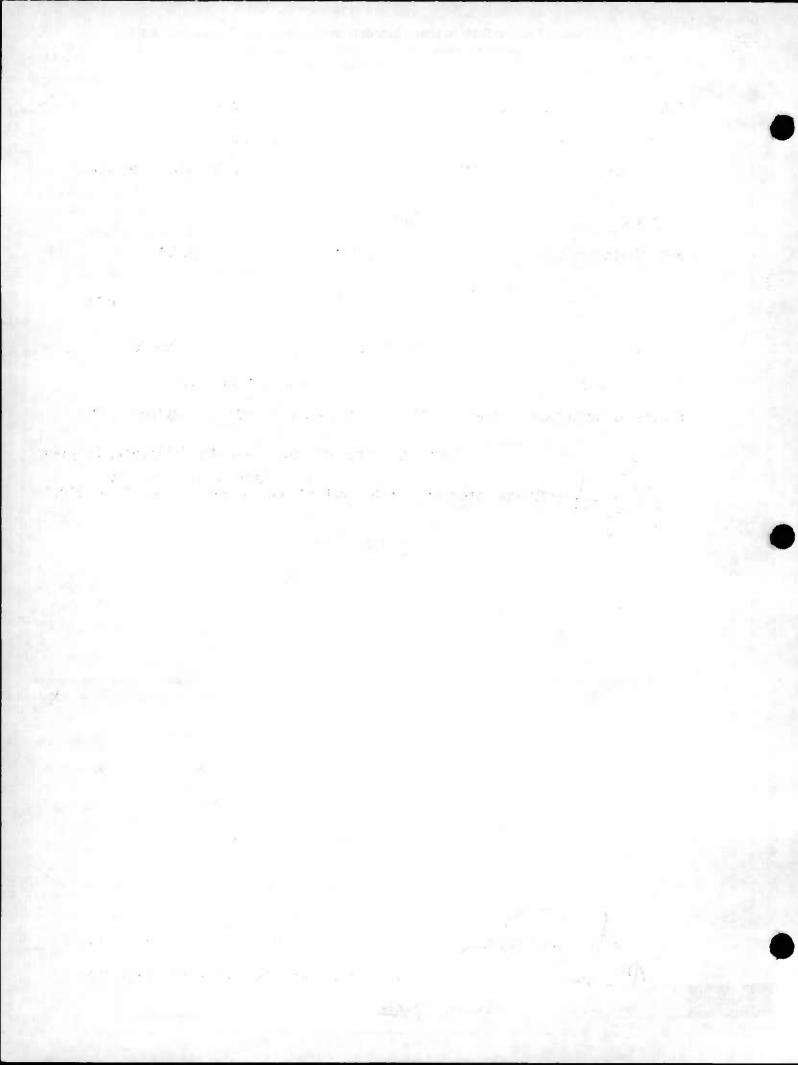
30. Name and a

cause of deeth (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

JULY 26, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Depart

	2. Dete of Death			3.	Time of	Deeth
ficate of Death	Reg. No.	0	6	J	15	1
ment of Health and	mental Hygiene	00	(7)	(*)	1 1-	8

Month

Physician · /Medical Examiner

Director

Funeral

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Completed

Be

10

Examiner

Physician/Medical

ģ

Completed

Certification: To Be

Medical

4a Facility Name (If not institution, give street and number) 1404 ANGLESEA STREET APT.2A

1. Decedent's Name (First, Middle, Last)

JULY 21, 4b. City, Town, or Location of Deeth

BALTIMORE CITY

Dey 1998 0804AM 4c. County of Deeth

Funeral Director

item 27 is marked other than "natural", or items 23s or 28a-f show other traumstic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than "netural", or flen any Injury or other traumatic event, It a Medical Examinar

Maryland 21215-0020

Baltimore,

212-30-3365 Usual Residenca of Decedent 10a. State

10c. City. Town or Location

Vrs

Lawrence Joseph Grembocki

7. Age (In yrs. last birthday)

66

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 27, 1931

Birthplace (State or Foreign Country)
 New York

death with the Marylend

Maryland

5. Social Security Number

Baltimore City

10d. Inside City Limits Yos 2 No

10e. Street end Number 1404 Anglesea Street

12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A. 14. Race - American Indian, Bleck, White, etc.

15X Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

N/A

1⊠M 2□ F

1 Yes 2 No Specify

21224

Specify: White 16b. Kind of Business/Industry

10g. Citizen of What Country?

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman

10f. Zip Code

Seafearers Assn.

17. Father's Name (First, Middle, Last)

Stanley J. Grembocki

18. Mother's Name (First, Middle, Maiden Sumame) Sophia P. Bollart

19a. Informant's Name/Relationship (Type, Print) Patricia Tribett

Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cametery, crematory or other placa)

212 Southwood Road Pasadena, Maryland 21122 20c. Location - City or Town, State

20a. Method of Disposition

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Crownsville VA Cemetery July 27,1998 Crownsville, Md.

21. Signeture of Funeral Service Licenses

22. Name and Address of Facility
McCully-Polyniak Funeral Home

AT Honosusporie CAMIONASCUM DUGOSE

3204 Mountain Road Pasadena, Maryland 21122 Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death

Physician /Medical Examiner

physicien end is the burief-transit

ettending p

signed by the e

peen

After this certificate funeral director, pag

To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun

page 2 hes

certificate be exec

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequenca of):

Due to (or es a consequence of)

Due to (or as a consequence of)

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24a. Was an eutopsy performed'

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical .1⊠ Yes 2□ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient 2 ER/Outpatient 3 DOA

26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 Yes

2 3 No

27. Manger of Death Natural 2 Accident 3 Suicide

4 | Homicide

5 Pending investigation 6 Could not be determined 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) and manner steted.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year) JULY 21, 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) A. Konsu DURNOS

W/ 111 Penn Street, Baltimore, Maryland 21201 A hogistians agnature Randon

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

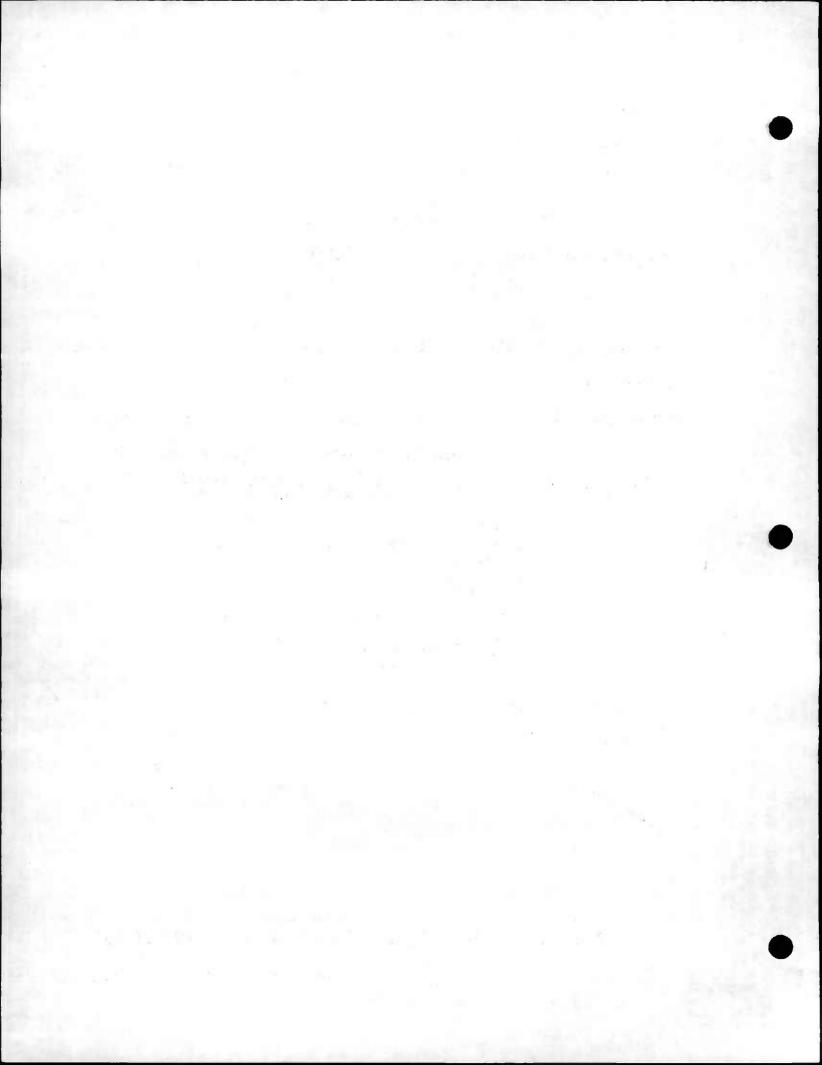
State Registrar

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8 23 152

		Certificate of Death	Reg. No.	40104
	Decedent's Neme (First, Middle, Last)		2. Dete of Deeth	3. Time of Deeth
Physician	EUGENE GRAY, JR.		Month Dey 25 - 98	Yeer 2:10 Am
· /Medical Examiner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or	Location of Deeth 4c. County	of Deeth
LAAIIIIIEI	4006 GELSTON DRIVE	Butine	1	NIA
5	5. Sociel Security Number 6. Sex/ 7. Age (In yrs. le	est birthday) If Under 1 Year If Under 24 Hrs	8 Date of Birth	Birthplece (State or Foreign Country)
Funeral Director	220-20-4109 10M 20F 68	Yrs. Months Deys Hours Min.	(Month, Dey, Year)	Country) MD
Director	Usuel Residence of Decedent		4-1-6-	1119
end #		, Town or Location		10d. Inside City Limits
Aaryler r show	mo NA BAL	Bassas		1 ☑ Yes 2 ☐ No
with the Maryle or 28a-f show be notified at	10e. Street end Number	TIMORE 101. Zip Code	10g. Citizen of V	What Country?
# 0 R 0		0: 500		
ifer deeth with the Manyland freme 23a or 28a-f show fiver must be notified at Funeral Director	4006 GEISTON URIVE	2/229	US	Y *
	11. Meritel Status 12. Was Decedent Ever in U,S Armed Forces?	 13. Was Decedent of Hispenic Origin? (S If Yes, specify Cuben, Mexican, Puer 	to Rican, etc.)	a - American Indien, k, White, etc.
2 to 1 1	1 Never Merried 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Specify	7
d within 72 hours efter giene. The Medical Eramina in the modeled by Fu	3 ☐ Widowed 4 ☐ Divorced Year or Detes:			BLACK
ed within 72 hour ygjene. Ner than "natural it, in Medical E	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usuel Occupetion (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. Kind of Bu	isiness/Industry
within ene.	Elementary/Secondary (0-12) College (1-4or 5+)		1	0
d withing or than a transfer t	10 TH GRADE NIA	CRANE UPERATOR	FRMCO	STEEL
be filed tal Hygin d other event,	17. Fether's Neme (First, Middle, Last)	18. Mother's Ner	me (First, Middle, Meiden Surnem	θ)
Venta Venta	EUGENE GRAY	MARY	BRICE	
d 2 should be filed vit and Mental Hygie 7 is marked other traumatic event, tr	19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Ri		Stete, Zip Code)
gos 1 and 2 should be filed to f Health by the d Mental Hy to for other traumatic event,	BESSIE GRAY WIFE	4001 GEISTON DO	BOUTO MD. 2	1229
Head	20e Method of Disposition 20b. Ple	ece of Disposition (Name of	Dete 20c. Location -	City or Town, Stete
bernit. Peges 1 er Depertment of Hea mportant: If Item in y Injury or othe	1 Burial 2 Cremation 3 Removel from State	metery, cremetory or other place)	1/00/00 Bar	MO
tme tant		UTUS CEMETERY	7/28/98 BALTO.	MD
permit. Peges 1 end Deperment of Health Important: If Item 27 any Injury or other to pnce.	21. Signature of Funeral Service Licensee	22. Name end Address of Fecility	E FUNERAL SE	0
205 60	Vaugh Cotteen	5151 BAITS ACATI		1D. 21229
	23a. Part1. Enter the disease, or complications that caused the death.	. Do not enter the mode of dying, such es cardia		Approximete
Physician	shock, or heart failure. List only one ceuse on each line.			Intervel Between Onset end Death
/Medical	Immediate Ceuse (Final	Liti tol	1 . 4	
Examiner	disease or condition resulting in death)	anter of me	Wei -	
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the attented for u	Part II. Other significant conditions contributing to deeth but not resu	Iting In the underlying cause given in Pert I.	23b. Did tobacco uee cor	ntribute to the cause of death?
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been s should	eller mits		performed?	eveileble prior to completion of cause
hes by ge 2 s			1	of deeth?
The tarte he page			1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 🗹 No
Physician: The this certificate ral director, par	25. Wes case referred to medical examiner?	26. Plece of De	eth (Check only one)	
hysic als ce I dire	Hospital:	ER/Outpetient 3 DOA Other: 4 Nursing H	Home 5 Residence 6 Oth	er (Specify)
er this seral di		28b. Time of 28c. Injury et Work?	28d. Describe how Injury occurr	red
or Attending Physician: The law requires the effect dark. Silvector: After this certificate has been signed in by the funeral director, page 2 should be estification: To Be Completed by	1 Neturel 5 Pending (Month, Dey Year) 2 Accident Investigation	Injury Work? M 1 Yes 2 No		
Attending in death. Sector: After by the fune fification	3 Suicide 6 Could not be 28e. Placa of Injury - At hor	me, farm, street, fectory, office	28f. Location (Street and Numb	er or Rurel Route Number,
Direction	4 Homicide building, etc. (Specify,		City or Town, Stete)	
filled and	29a. Certifier 1 Certifying Physician: To the best of my know	dedge death essured at the time date and place	and due to the squee(s) and me	appear on stated
ne Hospital or Attending P n 24 hours efter death. ne Funeral Director: Attert pletely filled in by the funer. edical Certification:	(Check only 2 Medical Examiner; On the basis of examinati	on endor investigation, in my opinion, deeth occ	urred et the time, date end place,	end due to the ceuse(s)
To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral Medical Certification	4	20e t leenes sumber	and Data stars	d (Month Day Vans)
1 × 10 × 10 × 10 × 10 × 10 × 10 × 10 ×	29b. Signeture end title of confider	29c. License number	29d. Dete signe	d (Month, Day, Year)
	VI grana X	1 18846	7/24	148
0	30. Name end eddress of person, who completed cause of death (Item,	23a) (Type, Print)	0 11	
0	N.M. Raw	DI St Paul DS	Epec Suct	579 21202
State	31. Date filed (Month, Dey, Yeer) 322 Registrar's Signet	ure		
_ State	111 201000 Grava Daindren	- Gandell		

DHMH 16 Rev 6/95



with the Maryla

Baltimore, Maryland 21215-0020

law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔾 🌣 Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Daeth 3. Tima of Deeth Day **Physician** 24, Laura A. Hoodicoff JULY 1998 12:58 PM * /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 3939 ROLAND AVENUE APT.#115 BALTIMORE Baltimore City If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 🛱 F 423-42-6542 Yrs 73 Director Feb. 18, 1925 Canada Usual Rasidanca of Dacedent 10b. County 10c. City, Town or Location 10d. Insida City Limits show 7 is merked other than "natural", or items 23s or 28s-f shos traumetic event, the Medical Examiner must be notified at Baltimore Maryland Baltimore City 1 Tyras 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 3939 Roland Avenue 21211 Funeral Was Decadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. Was Decadant Evar in U,S. Armad Forcas? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Isem 27 is marked other than "natural", or its any injury or other traumstic event, the Medical Examine. 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married White 1 ☐ Yas 2 XNo Specify. ģ 3 Widowad 4 Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hospital 12 Nurse 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be unknown unknown To 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 StDonation 5 ☐ Othar (Specify) 21. Signatum of Fe neral Sarvice Licensea Ronald S. Wade, Director 22 Nama and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 11. Enter the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, ck, or heart fellure. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** cartiovasculas Isase /Medical mmediata Causa (Final disaasa or condition rasulting in deeth) Examiner Dua to (or as a consequence of) Examiner anding physician end use as the burial-transit Sequantially list conditions, if eny, leading to immadiata causa. Enter Undarlying Causa (Diseasa or injury Dua to (or as e consequance of) Physician/Medical that initiated avants Dua to (or as a consequanca of) rasulting in daath) Last ettending p 23b. Did tobacco usa contributa to the cause of death? Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part f. been signed by the should be detached 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to completion of causa of deeth? Completed 24a. Was an autopsy 2**X** No 1 ☐ Yes 2 ☐ No certificate 1 Yas offer death.

Director: After this certifications director, 25. Was casa rafarrad to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa XX Rasidanca 6 Othar (Specify) XXYes 2 No 5 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 28c. Injury et Work? 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and dua to tha causa(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the causa(s) and mannar stated. 29a. Cartifiar Medical To the To the To the title of certifier 29d. Data signad (Month, Day, Yaar) 29b. Signature and 29c. Licansa number JULY 25, 1998 O.C.M.E 30. Name and ed causa of daath (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (N

tn, Day, Year)

2 9 1998

32. Ragistrar's Signature

chie Devidson

DHMH 16 Ray 6/95

A 1300 151

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Yeer Month **Physician** 11:00 PM Hanna 4b. City, Town, or Location of Death 23, 1998 /Medical 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 13a 1to tre N/A Judley Hours Min. J AN 23, Year) 925 If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Days 1 □ M 2 □ F 73 Yrs SC 219-20-8629 Director Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No MD N/A Director BALTO 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2530 E. HOFFMAN ST 21213 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 5th LABORER AMERICAN STANDARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 ABRAHAM HANNA AMOND EADDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HATTIE COURSER 2530 E. HOFFMAN ST BALTO, MD 21213 20b. Place of Disposition (Name of complete), crematory or other place)
MT • ZION CEM Date 20c. Location - City or Town, State Caurial 2 ☐ Cremation 3 ☐ Removal from State 7-29-98 BALTO, MD 22. Name and Address of Facility BETTS FUNERAL HOME 21. Signatule of Funeral Service Licenses 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4□ Nursing Home 5₽Residence 6 □Other (Specify) Hospital: 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

attending physician and if for usa as the bunal-transit tha death certificate be executed Records, P.O. Box 68760 8 peen has certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director.

Division of Vital

with the Maryland

death

filed within Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important; If them 27 is mented other any Injury or other trauments.

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or flams 23e or 28e-f show traumatic event, the Medical Examiner must be notified at

Certification: To the Hospital or within 24 hours aft To the Funeral Di completely filled in

6 Could not be determined 4 ☐ Homicide

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier

29a. Certifier

Medical

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State

Registrar

29c. License number

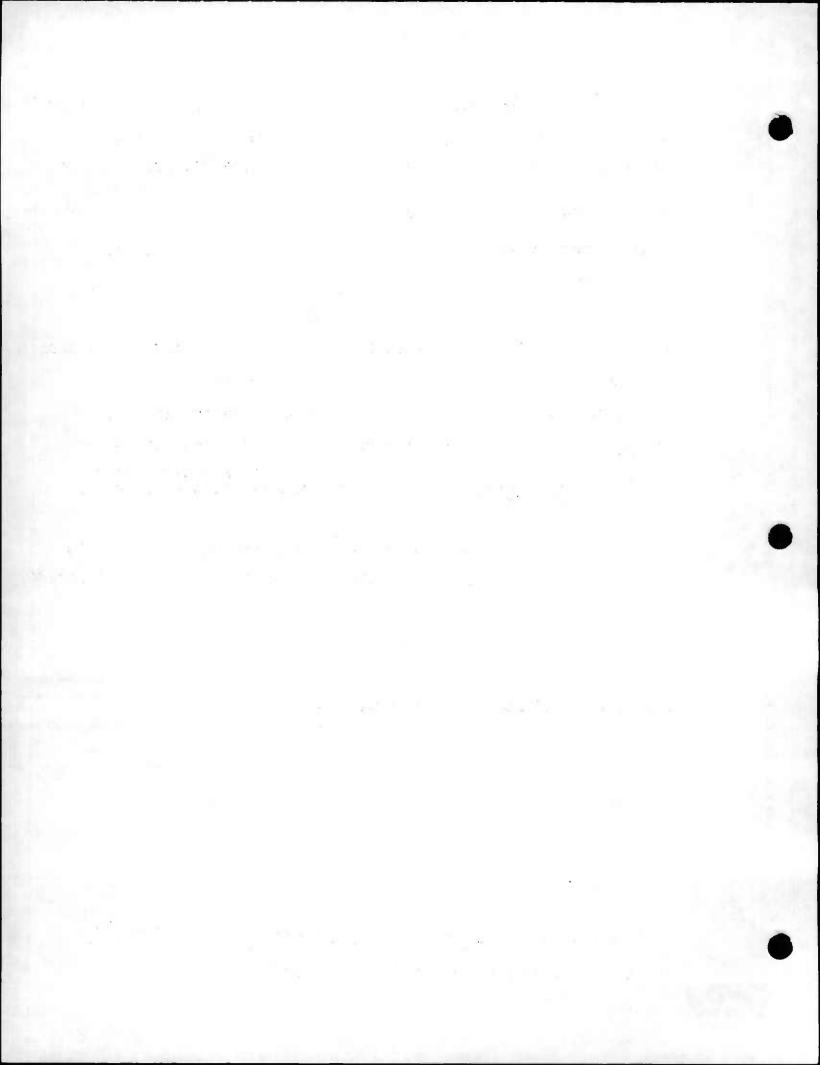
29d. Date signed (Month, Day, Year) 8

30. Neme end address of person who com eted ceuse of deeth (Item 23e) (Type, Print) MA

6 31. Dete filed (Month, Dev. Year) 2 91998

320 Registrar's Signature Julia Davidson-Randalle

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Yee Month MAZOLA HIGGINS 4b. City, Town, or Location of Death 1998 23 2:50am 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth 584 S. Beechfield Ave Baltimore NA 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 1 M 2 K F Days Months Yrs. SC 248-50-2283 10 8 Usual Residence of Decedent 10a. Steta 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21229 584 S. Beechfield Ave U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decadent of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Leasing Management Eutaw Garden Apts 12th grade na 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Daisy M. Hudson Ben E. Prioleau 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John Broadway-son 20e. Method of Disposition Baltimore Md 21229 584 S. Beechfield Ave, 20b. Place of Disposition (Name of cemetery, crematory or other pleca) Dete 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State Calvary Cemetery 7/27/98 Glen Burnie, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetura of Funaral Sarvice Licansae 22. Nama and Address of Facility March F/H West lady Warne 21215 4300 Wabash Ave, Baltimore, Md 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Daeth immediete Ceuse (Finel disaese or condition resulting in death) metastatic breast cancer 5 years Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequença of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evallebla prior to completion of causa of death? 24e. Was en autopsy performed? 2 No 1 ☐ Yas 2 No 1 ☐ Yas 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred

Examiner Division of Vital Records, P.O. 8 certificate has Hospital or Attending Physician: director, this After daath. aftar daat

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Physician/Medicai 24 hours

Physician

/Medical

Examiner

Funeral

Director

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item 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Expresser must be a

al Hygiene.

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy, important: If flem 27 is marked oths any injury or other traumatic event, page.

Physician

/Medical

Examiner

Baltimore,

Director

Funeral

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Completed

Be

the Maryland

filed within 72 hours after

To the Hosp within 24 hou To the Fune completely fi

Certification:

Natural

2 Accident

3 Suicide

4 ☐ Homicide

29a. Certifier (Check only one) 29b. Signature and title of certifier

Injun

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Dawson

29c. License number D28239

2 No

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Onesly Center

NANCY DAVIDSON

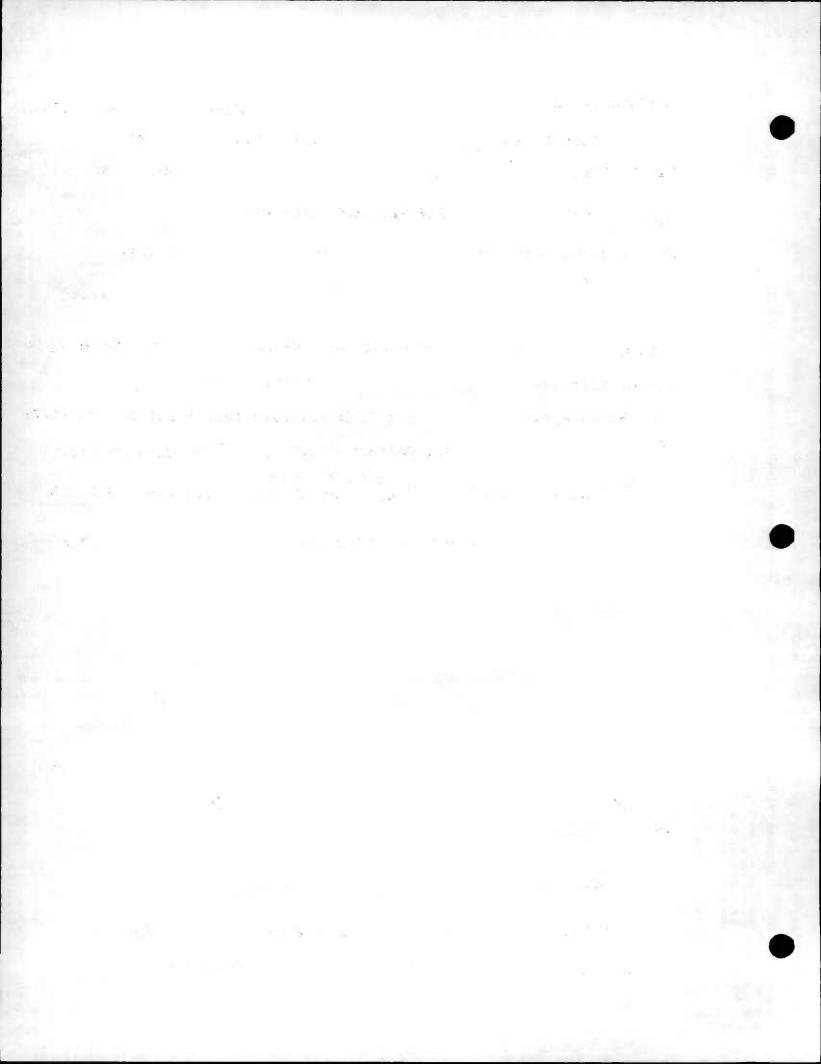
State Registrar 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

32_Registrar's Signatura 4 Sia Davidson Randall



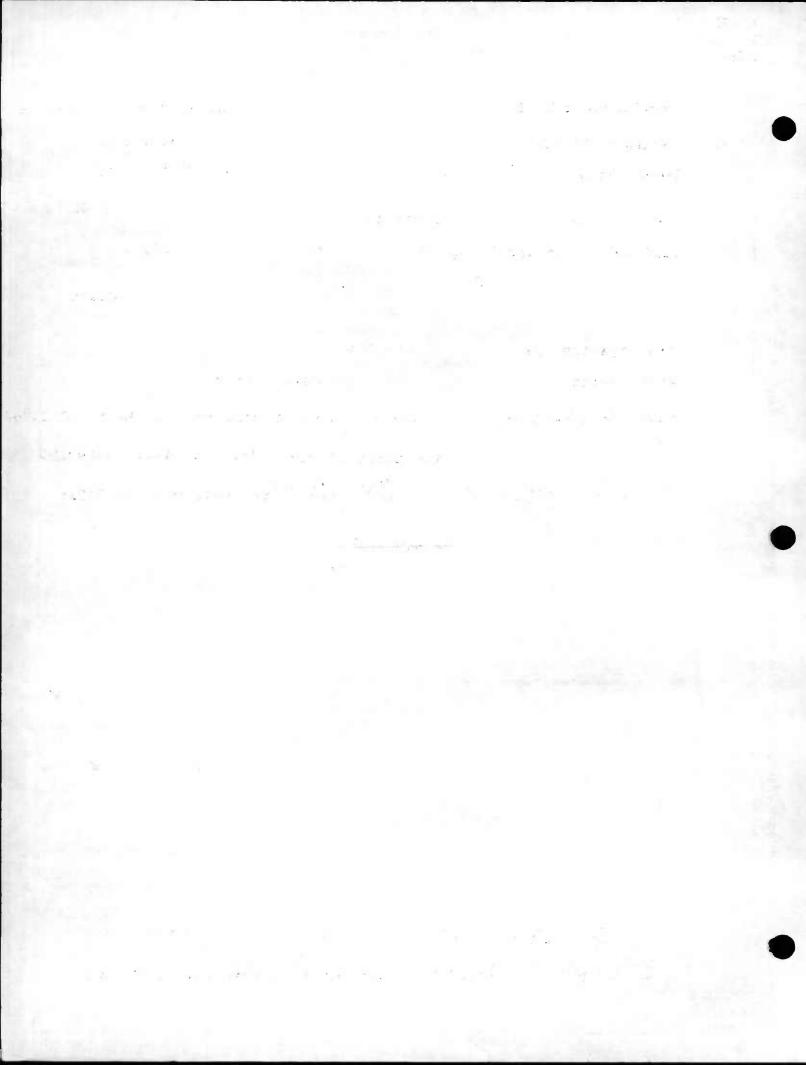
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State of Maryland / Department of Health and Mental Hygiene

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or 28	109. 5	Street end Number					10f. Zi	p Code			10g. Citizen of	Whet Cour	ntry?
th will	B 72	18 Oak Ha	ven	Circle	Apt	303		2124	44		U.S.A	A .	
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Page Manual Manu		☐ Donetion 5 ☐ Othe				na N	demor:	ial	Park	7/29/98	Randa	llst	own, Md
permit. Pag Department Important: I any injury o	21. S	ignatural Funeral Sen	vice Lican	See			22. Name e	nd Addre	ess of Fecility				
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Physician: The lav this cartificata hes rel director, page 2		xeminer? XYes 2□ No		Hospital:	atient 2X	ER/Outpe	tient 3 D	OA Oth	007:	Home 5□Res		her (Snecil	v)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month is 55 PM ALBERT FRANKLIN HUNT, SR. 1998 25 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Days 180 M 2□ F Yrs. 235-46-6899 OCT 7,1931 KENTUCKY Usual Rasidanca of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5 HOLMES AVENUE U.S.A. 21228 12. Was Decedent Ever in U,S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: KOREAN Was Dacedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2₺ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MECHANIC 12TH GRADE CHEMICAL COMPANY 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WARD HUNT IRENE MEADOWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) ALBERT F. HUNT, JR (SON) 2400 SMITH AVENUE - ARBUTUS, MARYLAND 21227 20b. Place of Disposition (Name of cemetery, crematory or other placeREMATORY 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/98 LAUREL, MARYLAND BALTIMORE/WASHINGTON HUBBARD FUNERAL HOME INC. of Funera Sarvice Licens 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Immediate Causa (Final disease or condition rasulting in death) Acute ongestive ears Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): ORONARY Due to (or as a consequence of): rasulting in death) Last Mel Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Fm LURE 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 XNo 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 5 Panding investigation 1 Natural Injury 1 Yas 2 No 2 Accident 6 Could not be determined

Physician /Medical Examiner

Physician

- /Medical

Examiner

MD

Direct

Funeral

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Funeral

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Experient must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelth and Mental Hygiene. Important: if flem 27 is merked other than "natural", or fee any injury or other traumatic evens.

altimore.

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Examiner certificate be Physician/Medical

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Completed

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Certification:

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3 Suicide

29a. Certifier

4 Homicida

Box 68760, After this se Hospital or Atten-24 hours after deeth. —I Director: Af To the Hosp within 24 hou To the Fune completely fi

of Vital Division

FRANKLIN

29b. Signature and title of certifiar Kaukon e

29c. License number

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) N UTOMBO

IT HONES CANGO NOVE 31. Date filed (Month, Dey, Year) 1998

32. Registrar's Signature Lulia Davidson Randale

28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

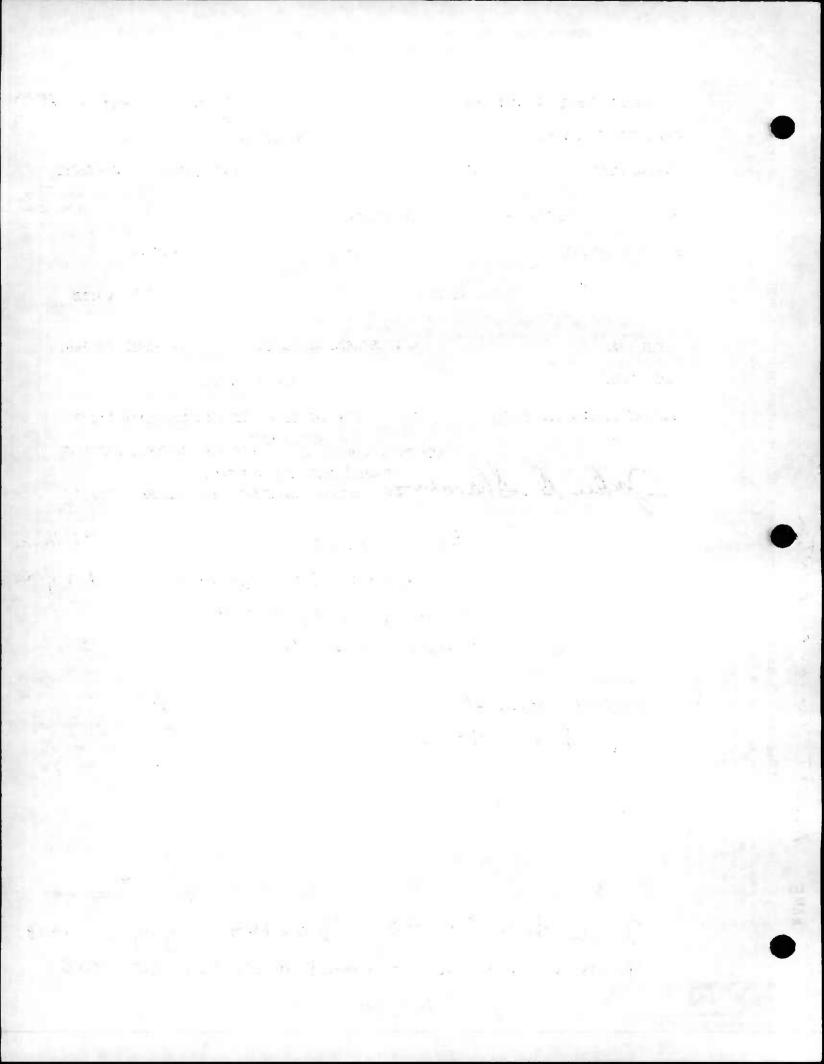
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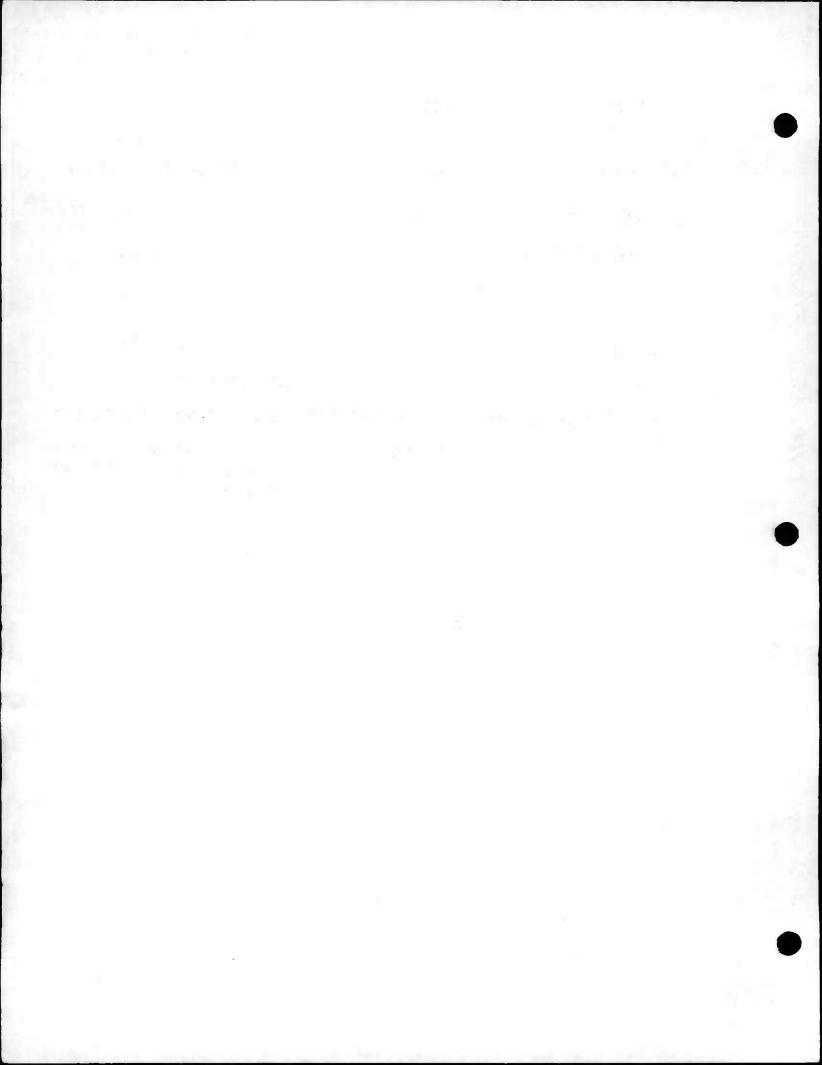
HOSPITAL,

28f. Location (Street and Number or Rural Routa Number, City or Town, State)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle,	Last)		Corun	cate of l		2. Date of Dec		3. Т	ime of Death
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Examiner		le. Fecility Name (If not institution, g		1	12	1 - 1	b, City, Town, or	Location of Death			
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O C	3	10th grade 17. Fathar's Name (First, Middla, La	st)		LADONLI	·	18 Mother's Na	me (First, Middla,			
atic eve To Be	5	DANIEL HEMSLEY						JANIE HEI			
umat		19a. Informent's Neme/Relationship	(Type, Print)		19b. Mailing Ad	dress (Street		urel Route Numbe		Stete, Zip Code;)
ar tra		Lindora Hemsley	/ Daughter		2320 Dr	ruid Hi	11 Aven	ue, Balt	imore,	aryland	21217
or oth	2	20a. Method of Disposition		20b.	Plece of Disposition cemetery, cremeter	(Neme of or other place		Dete		City or Town, St	
jury o		4 ☐ Donetion 5 ☐ Othar (Space	city)	P	RBUTUS ME			7-28-98			
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dical miner	1	Immediate Cause (Final disease or condition resulting In deeth)	· Carc		na of or es e consequence or a or es e consequence		Lui	ng			
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detached to Physic								10	Yes 2□ No	3 Probably	4 DUnkno
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page 2								101	as 2 No	1 ☐ Yes	2 No
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0 0 0	2	27. Manner of Death 1 Netural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not	be		28b. Time of Injury		y et ⟨? Yes 2 □ No	28d. Describe I			
completely filled in by the fun		4 ☐ HomicIde determine	building, e		ome, farm, street, fo			City or Tox	m, Stete)	ber or Rurel Rout	e Number,
pletaly fill		29a. Certifier (Check only one) 1 ☐ Certifying F 2 ☐ Medical Ext	Phyelclen: To the besi aminer: On the besis end menner s	of examina	owledge, deeth occu ation end/or invastig	rred et the tim ation, in my op	e, date end plac pinion, death occ	e, end due to the ourred et the time,	ceuse(s) end me date end place,	enner es steted. end due to the co	euse(s)
E COU	2	29b. Signature end title of portifier	I.M S).		29c. License	050 number		29d. Date signe	d (Month, Dey, Y こ 引	'ear)
	3	00. Name end address of person wh	o completed cause of	deeth (Ite	m 23e) (Type, Print)			enera	1 1	1-11-1	1
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item 20b.c Per FH Film G762 8-6-98 rja Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Daeth **Physician** WALTER WILLIAM 29 1498 4c. County of Deeth 05:00 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deets Examiner (OFENERAL ERAL Hos 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, land If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number Birinplaca (Stata or Foreign Quantry) **Funeral** Sex 1 M 2 □ F Months Days 75-18 73 Hours -5011 Yrs. VOV. 05 Director VIRGINIA Usual Rasidance of Decedent Pages 1 end 2 should be filed within 72 hours eftar death with the Maryland nent of Haaith end Mantal Hygiene. Int: If Hem 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ? is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Expresse must be notified at 1 Yes 2 No Director MARYLAND 10e. Street end Number og. Citizen of Whet Country? FRANKLIN ST. APT. 1408 Funeral USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 +H GRADE ATTENDANT AMBULANCE TOSPITAL 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be 10 KEBECCA UNKNOWN COTT 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 s Depertment of Haaith en Important: If Item 27 is any Injury or other trau 124 W. FRANKLIN ST., BALTIHORE, MD. 2120 J se of Disposition (Nema of Date 20c. Location - City or Town, State ANDRE IVEY/RUTH IVEY (SON + WIFE) 20b. Plece of Disposition (Nema of consider, come lovy or other plece)
King Memoria Park 20a. Mathod of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from State Woodlawn, MD. 4 Donation 5. Other (Specify) HARVLAND 22. Name end Address of Fecility

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29. Na Approximete Interval Batween Onset end Death **Physician** Immediate Ceuse (Finel diseasa or condition resulting in daath) /Medical Examiner Physician/Medical Examin car The law requires that the death certificate be executed ician and buriel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaase or Injury that Initieted events rasulting in death) Lest Records, P.O. Box 68760, CInoma the Due to (or es e consequence of) 98 ettending p ned by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown signed b þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Was an eutopsy page 2 certificate hes 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No Vital Attending Physician: Be 25. Wes cesa referred to medical examinar? 26. Placa of Daath (Check only one) To the Hospital or Attending Frigura-within 24 hours efter death. To the Funeral Director: After this c Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA ō 28c. Injury et Work? 27. Manyrer of Daath Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural Injury 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 ☐ HomicIda 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and dua to tha causa(s) and manner as steted.

2 Madicet Exeminer: On the best of exemination and/or investigation, in my opinion, daath occurred et the time, date end place, and due to the causa(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Data signad (Month, Dey, Year) Clo Maryland 6 30. Name and eddress of person who complated cause of daeth (Itan 23e) (Type, Print) PNghan YUKAL MD MANDreet

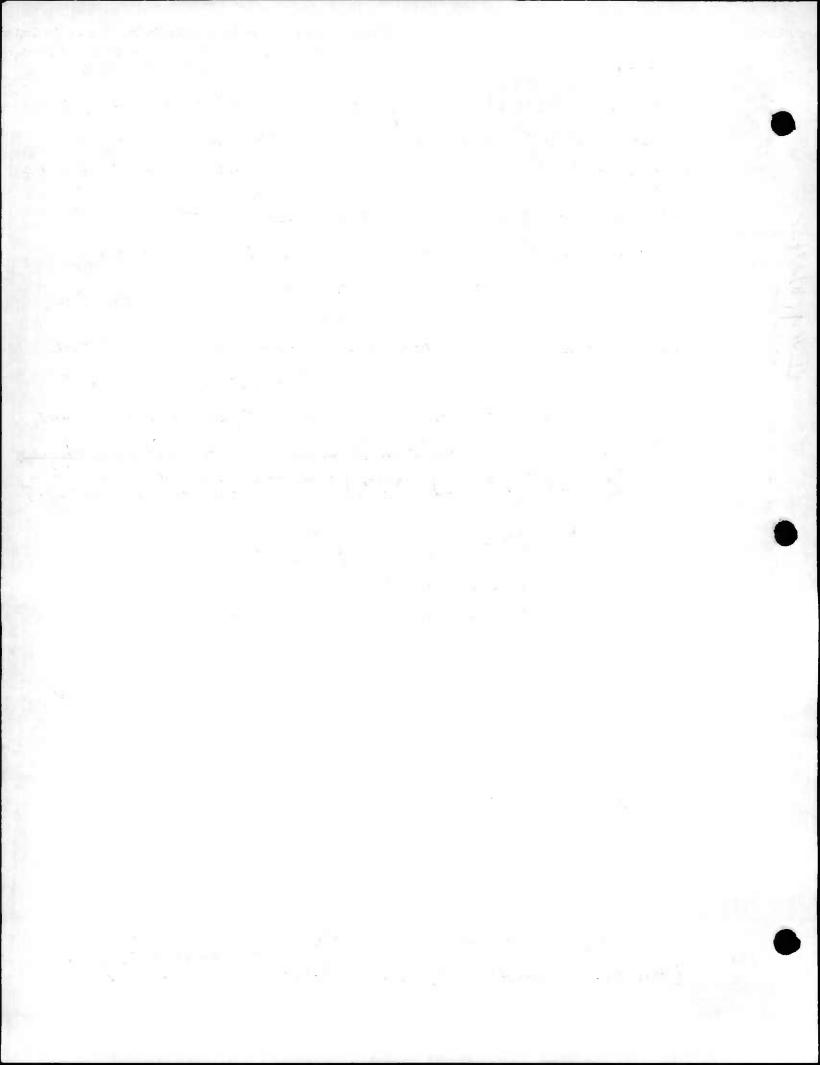
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31. Dete filed (Month, Day, Yeer)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month **Physician** BRYANT W. JONES 1500 498 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Ba 1to Hospital Deaton Home 7. Age (In yrs. last birthday) 34 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 8. Dete of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Deys Months Hours Min. 1 M 2□ F 219-80-7298 NOV 14, 1963 MD Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥Wes 2□No Director MD N/A BALTO 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4209 OLD YORK RD 21212 U.S.A. Completed by Funeral 12. Was Decedent Ever In U,S Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Rece - American Indian, Bleck, White, etc. 1 Tyes 2 No If Yes, Give Yeer or Detes: Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th N/A CLERICAL HOSPITAL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be WYLIE JONES MARGUARITA ROSENBERG 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MARGUARITA ROSENBERG/mother 4209 YORK RD BALTO, MD 21212 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, Stete WOODLAWN CEM 1 Burlal 2 □ Cremetion 3 □ Removel from State 7-31-98 WOODLAWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FecilityBETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD21213 1 Cld 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) noi ema mo Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert It. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? 24a. Wes en eutopsy 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify)

Examiner The law requires that the death certificete be executed buriel-tren physiclan the as ettending p ed by the e director, page 2 should be

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P.O. Box 68760,

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Physician

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, fra Medical Examiner must be notified an annual.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner þ Completed Be Certification: To s effer des.

1 Yes 2 No 27. Menner of Deeth 1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only onel

29b. Signature and titlelof certi-

5 Pending investigation 6 ☐ Could not be determined

Hospitel: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

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Balto,

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Year)

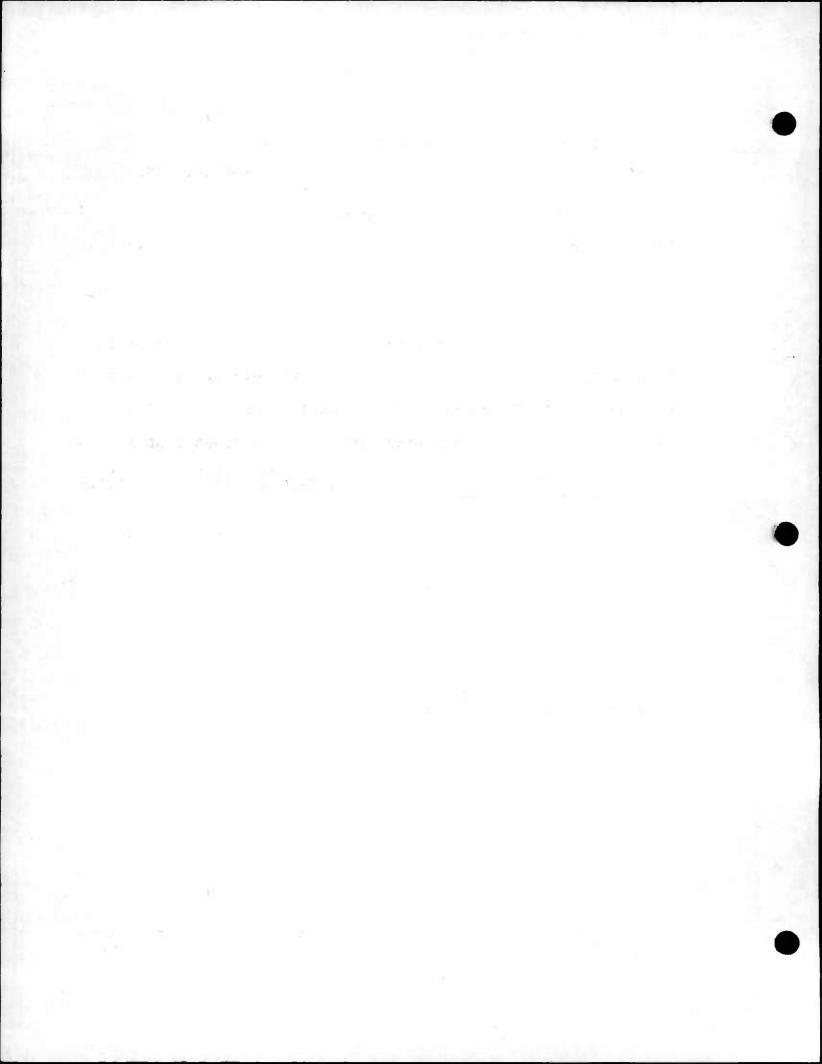
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30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

60 25 31. Date filed (Month, Pty, Yea) 91998 32. Registrers Florely Con-

State Registrar

Medical



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death July 28, 1998 130A ESSE INDRED 4b City, Town, or Location of Deeth Baltimore 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Hospital ohns HOPKINS Hours Min. 8. Date of Birth (Month, Day, Year) Undar 1 Year 7. Age (In yrs. lest birthday) 9. Birthpleca (State or Foreign Country)
Mary and 5. Social Security Number 6. Sex 231-07-903 Days 19M 20F Yrs Usuet Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA Baltimore 11 Yes 2 □ No 10f, Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 707 Gate Chaple 212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 20 No Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamentery/Secondary (0-12) College (1-4or 5+) BcM Steel worker 6Th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Kindre Shar James wife 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MKindred Baltomd 21229 Chaple Gate La Mabel 707 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. MetMod of Disposition Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 -1-98 owing mills ma Cem Garn son Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Addrass of Facility 5151 Baltmare Vaug Gracine 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) DAYS SPIRATION Due to (or as e consequence of) YEARS JAMOUS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) PALATE Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy parformad' 1□ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation Naturet 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

Examiner The lew requires that the death certificate be axecuted Records, P.O. Box 68760, Division of Vital

Physician/Medicai Examiner þ Completed Be P Certification:

Physician

/Medical

Examiner

Director

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Funeral

Director

the Marylend

d 2 should be filed within 72 hours after death with the Maryle th and Mental Hygiana.
7 Is marked other than "naturel", or items 23a or 28a-f show traumatic event, fro Madical Examines must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any Injury or other traumatic event, page.

Physician

/Medical

attending physician end for use es the burial-transit

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Baltimore, Maryland 21215-0020

ate hes been signed by the pege 2 should be detached certificate hes Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: Attar this certifice director, To the Hospital e within 24 hours e To the Funeral D

State

edicai

29a. Certifier

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31. Date filed (Month, Day, Yeer)

29b. Signature and title of cartifier

BRETT ZBAR JOHNS

29c. Licansa number

HOSPITAL

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es ateted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end menner steted.

29d. Date signed (Month, Day, Yeer)

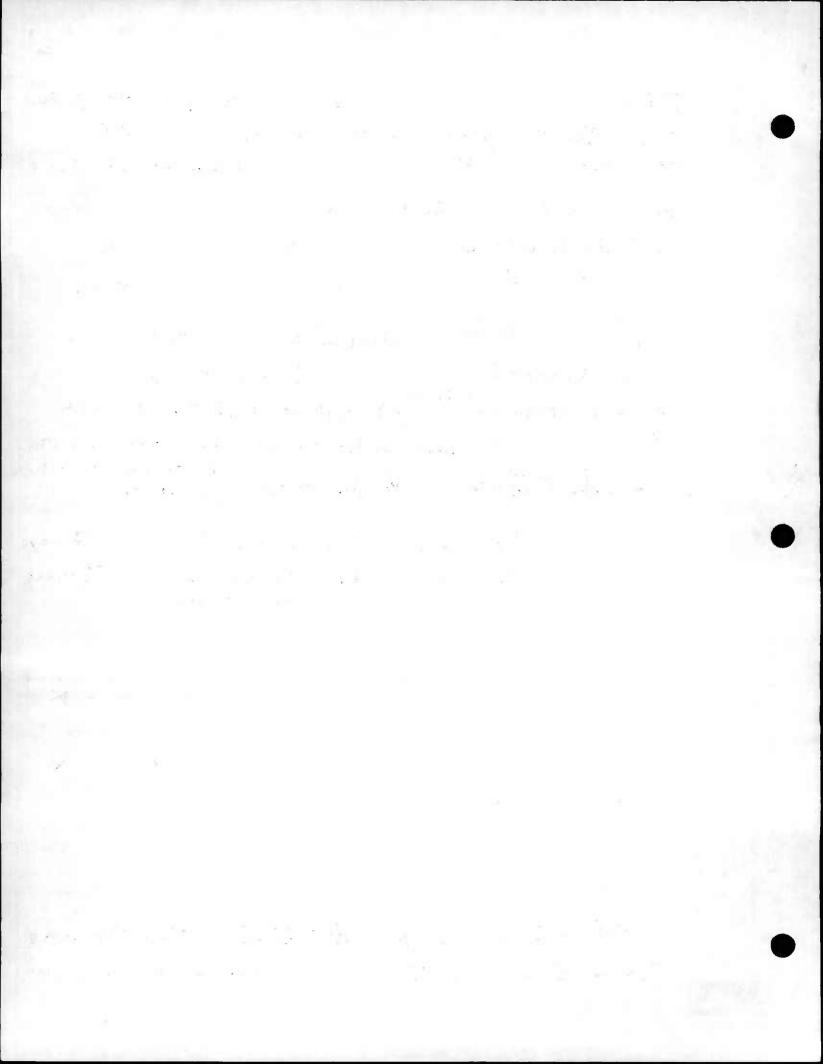
MA 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

mD

291998

32. Registrer's Signature John Savidson Bandace

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev LEONA LINDEMON July 23:02 1998 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth BALTIMORG Hospital HOPKINS Sohns If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) H Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Months Deys 1□ M 20 F 217-32-8727 63 Sept26,1934 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Dundalk 10e Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 1911 Codd Ave. 21222 USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Stetus 1 ☐ Yes 2½ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes Ž No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Board Of Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Education Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Paul Stiegmann Caroline Stiegmann 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1911 Codd Ave. Baltimore Md. 21222
of Disposition (Name of Dete 20c. Location - City or Town, Stete David Lindemon 20a, Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 1 ☐ Buriei 2 Cremetion 3 ☐ Removal from State Metro Crematory 7 - 28Catonsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) ignature of Furerat'S 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road 21222 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final HYPOTENSION 3 days disease or condition resulting in deeth) Due to (or es e consequence of): 13 days MYOCARDIAL INFARCTION Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as e consequence of): 13 years CORONARY ARTERY DISEASE Due to (or es e consequence of): 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No CEREBRAL VASCULAR DISEASE 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy HYPER TENSION 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

Show

Director

Funeral

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Completed

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Item 27 is marked other than "natural", or items 23s or 28s-f shot other trsumetic event, the Medical Examinet must be notified at

Permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiane. Important if Item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0020

with the Maryland

and burial-tran physician the use as signed by tha a d be datached f

Division of Vital Records, P.O. Box 68760,

requires that the death certificate be

Attending Physician:

er daath.

Physician/Medical þ Completed Be

Certification:

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25. Wes case referred to medical examiner? 1 Yes 2 No

> 1 Neturel 2 ☐ Accident 5 Pending Investigation 6 Could not be determined 3 Suicide

4 ☐ Homicide 29a. Certifier (Check only one)

28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Phyalcien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of cartifier Food B. Eller MO HOUSE OFFICER

29c. License number (RES-000 P2487

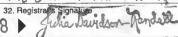
29d. Date signed (Month, Dey, Year) July 25, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

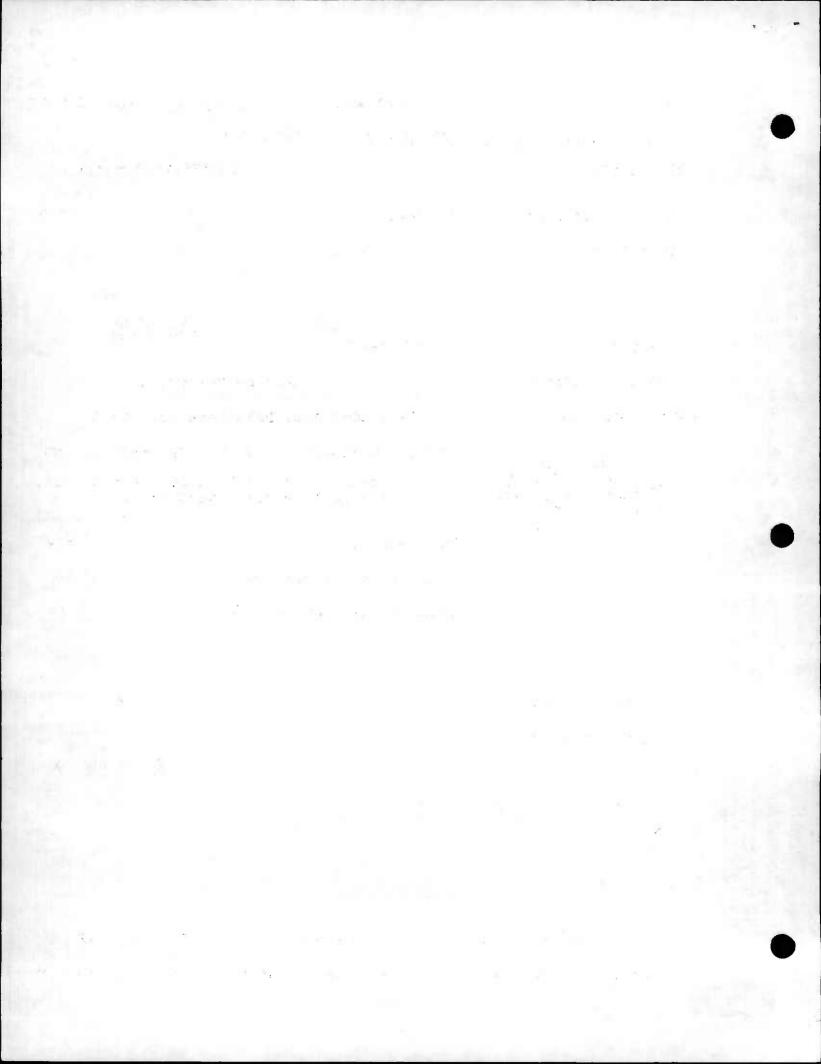
THE JOHNS HOPKIMS NOSPITAL 600 North Wolfe Street Baltimore, Maryland ELLERIN, MO

31. Date filed (Month, Day, Year)

291998 JUL



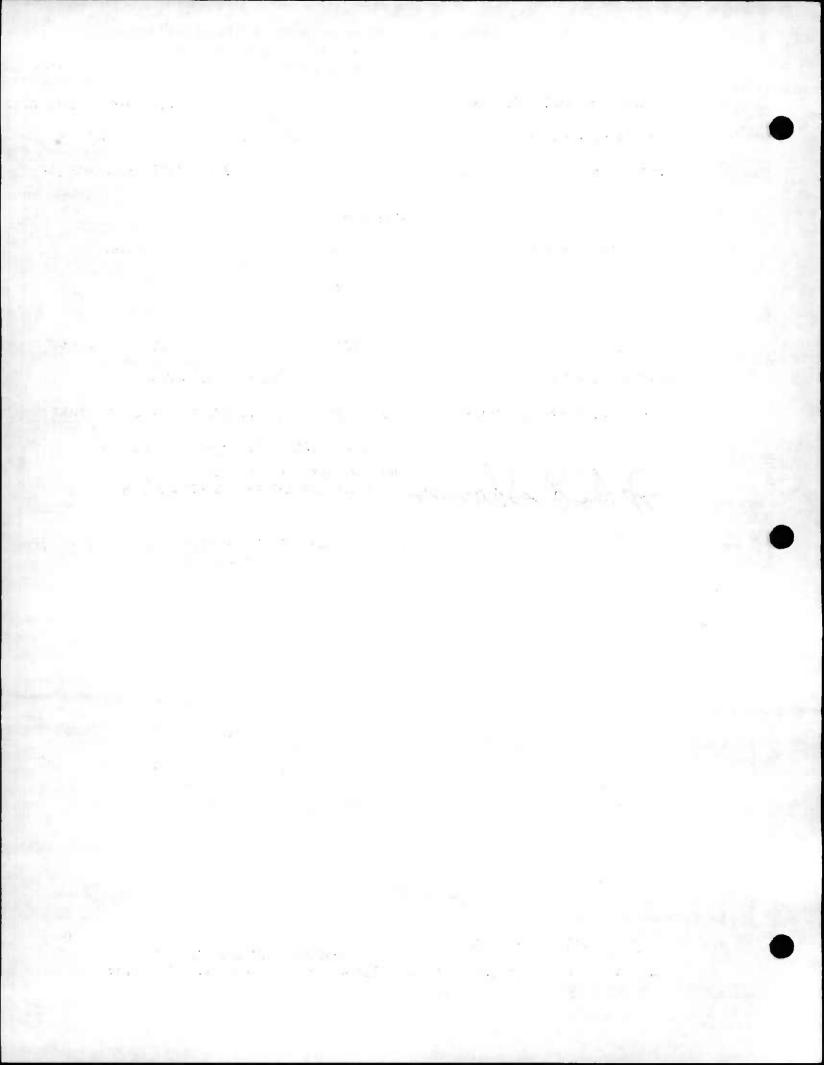
Registrar



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State of Maryland / Department of Health and Mental Hygiene 23 | 6 |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 98 Katie Virginia

4e Fecility Name (If not institution, give street and number) 12:50 PM 27 /Medical 4b. City, Town, or Location of Death 4a. County # Deeth Examiner ong Green Center-Genesis Eldercare Network enesis Eldercare Network Baltimore
7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Deys Hours Min. (Month, Day, 5. Sociel Security Number Birthplece (Stete or Foreign Country) 6. Sex **Funeral** Deys 1□ M 20 F 220-24-3739 Usuel Residence of Decedent 87 Director with the Marylend 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits lem 27 is marked other than "natural", or ferms 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at 1 Yas 2 No Director Himor 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 45A 2/239

13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Funeral 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status Armed Forcas? pernit. Pages 1 and 2 should be filed within 72 hours etter. Department of Haalth end Mantel Hygiane. Important: If item 27 is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 ₩idowed 4 Divorced by Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) isekee Vomestie ber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 0 Dobert ewi. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Parkery Ballo MD, 21239 Deta, 206. Location - City or Town, State Cillorthern larlene 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State ò 4/1/5 injury 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licanses eral Servi Fun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Culloh Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final PSIS disease or condition rasulting in death) Examiner Due to (or es a consequenca of). about 1 week Examin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or injury thet initieted events resulting in deeth) Lest Due to (or as e consequence of) ementa ears Physician/Medical Due to (or es e consequence of): ğ Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. ş The law requires that the s been signed by the should be datach 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy has 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: Certification: To 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28c. Injury et Work? 27. Menger of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aftar 1 Naturel injun 5 Pending 1 Yes death. 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, offica building, atc. (Specify) complataly filled in by 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner steted. edical 29e. Certifier (Check only one)

To the

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Dey, Year)

and address of person

29b. Signatuse and title of care

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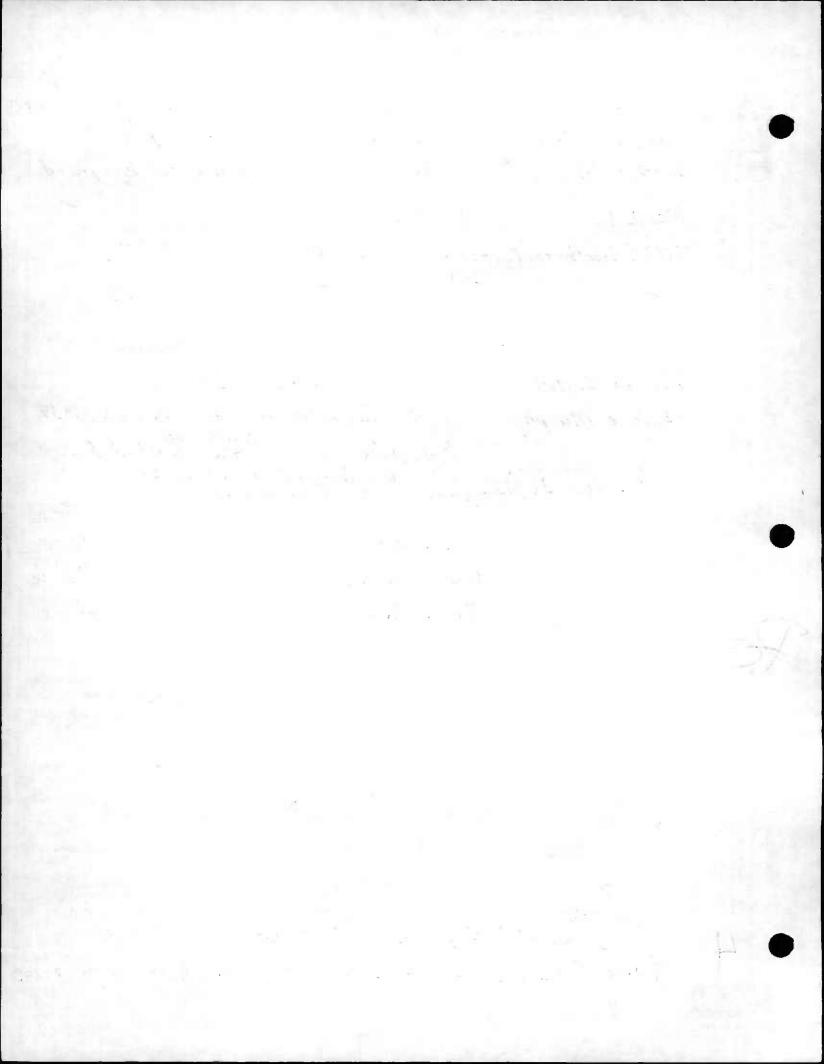
4000 Old Court Rd #203 Balkman Md 21208 M.D. WARTZ 32. Ragistrar's Signatura whia Davidson-Randall

who completed cause of death (Item 23e) (Type, Print)

29c. License number

29d. Dete signed (Month, Dey, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

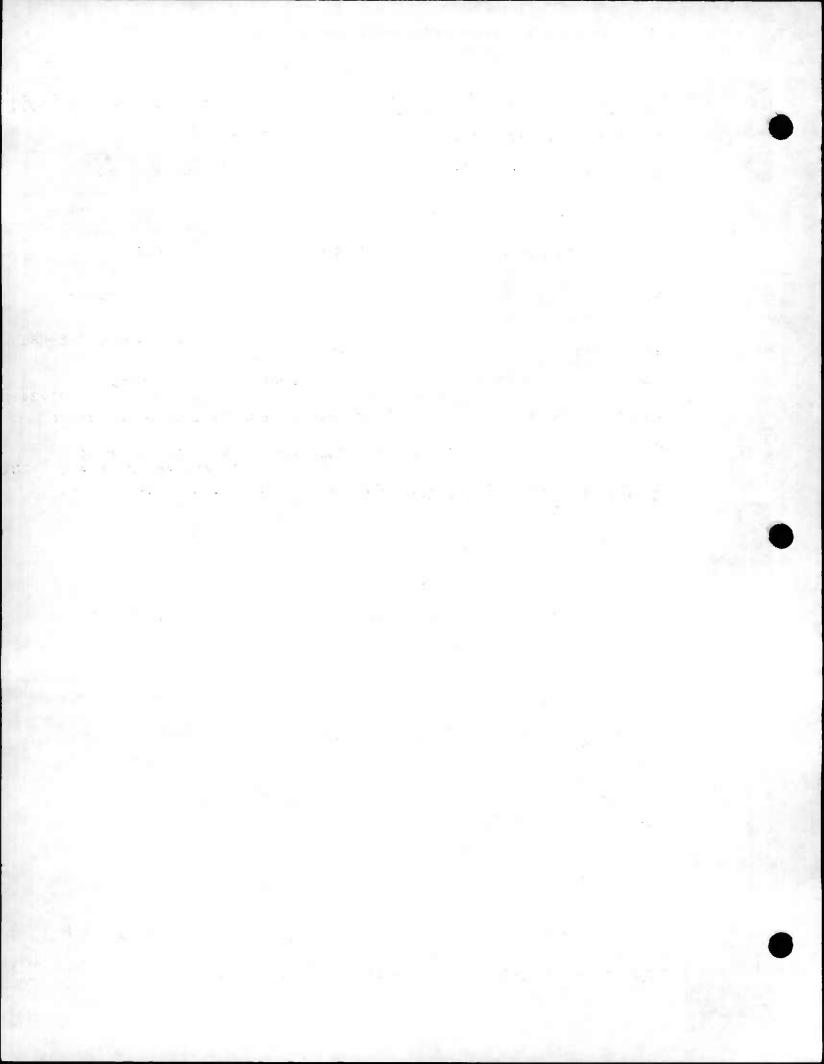
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dev **Physician** /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Long Green Nursing Home baltimore NA If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sex **Funeral** 1 ☐ M 2√2 F 89 Yrs. Director 04-10-09 SC 212-18-0587 Usual Residence of Decedent with the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiena. Department of Health and Mantal Hygiena. It is not seen a 23e or 28e-f show any injury or other traumatic avant, its Medical Examiner must be notified at once. X√Yes 2 No MD Director NA Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2729 Superin 21234 USA Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Š 3 Nidowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Sch. 12th Grade B.S. Degree Teacher 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Jack Brice Nancy 0 Unknown 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21234 19e. Informent's Name/Reletionship (Type, Print) Lelia J. Beal 2729 superin Avenue Baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 € Buriel 2 Cremetion 3 Removel from State Zion Canan Cem 4 ☐ Donetion 5 ☐ Other (Specify) 08-01-98 Columbia, SC of Euneral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23 Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List this enter cause on each sine. Approximate Interval Between Onset and Death Physician /Medical mediate Cause (Final Sepsis disease or condition resulting in death) Examiner Due to (or as a consequence of): densitions and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be exec Brady anythme Box 68760. physician Physician/Medical 2 the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 8 1 Yes ZETNo 3 Probably 4 Unknown signed by Hearenne requires that Records, þ 2 24b. Were autopsy findings available prior to completion of cause of death? Completed Tout 24a. Was an autopsy INW 768 page P P ALT NO 1 Yes 20 No t Ves certificate Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 T Yes 20 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Attending 5 Pending investigation 1 ENatural death. 1 Yes 2 No 2 Accident f or Attend after death Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 50 4 D Homicide To the Hospital (within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier LAC 7/28/9 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 821 N. EUTAW ST Ente 308 HASHMI un) 32. Registrar's Signature State rine Davidson-Randall

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** July 1998 24 LAW MOBLEY 10:00am /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 24 Hrs. | 8, Da 8705 Windor Mill Road If Under 1 Year 7. Age (In yrs. lest birthday) Dale of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Days **Vrs Director** 70 219-22-7711 Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at YYes 2□ No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8705 Windor Mill Road Funeral 21244 U.S.A. 14. Race - American Indian, death 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effect Department of Health and Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or then any Injury or other traumatic event, the Medical Property. 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Driver/Supervisor 12th grade 17. Felher's Name (First, Middle, Last) State of Md 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Law Mobley Sr. Nannie Foster 19a. Informani's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Elsie Mobley - wife 20b. Place of Disposition (Name of cametery, cremetory or other place)

8705 Windsor Mill Road Baltimore Md 21244

20c. Localion - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 7/28/98 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March f/H West 4300 Wabash Ave, Baltimore Md 21215

Approximate the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart fellure. List only one cause on each line. Intervel Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) 8 mos /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or es a consequence of): d for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy has 3e 2 s certificate has director, page 2 2 No 1 ☐ Yes 1 TYes 2 No or Attanding Physician: director, Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After thi 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury deeth. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 - Homicide n 24 hours eft e Funeral Di pletely filled in the Hospital Certifying Physician: To the best of any knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the best of any minetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edical 29a. Certifier pletely (Check only one) within 2 To the 29b. Signeture end little of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) 2 2 M

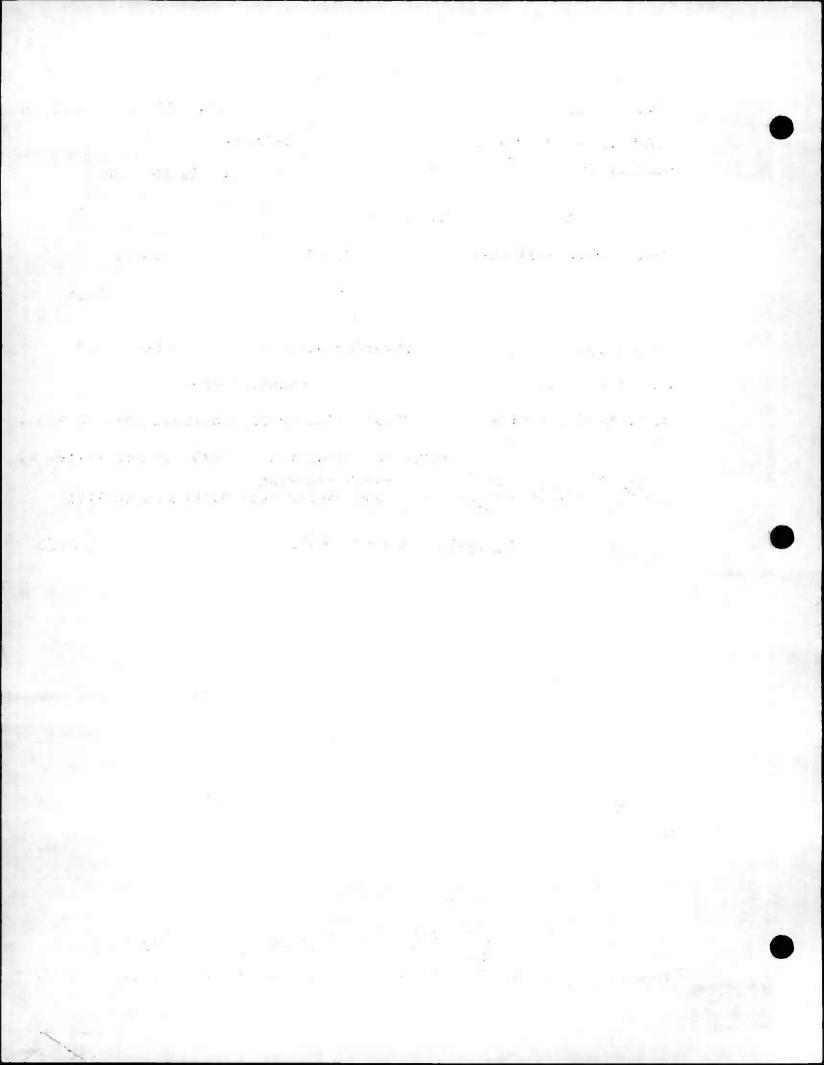
of death (Item 23e) (Type, Print)

Hopistrar's Signature

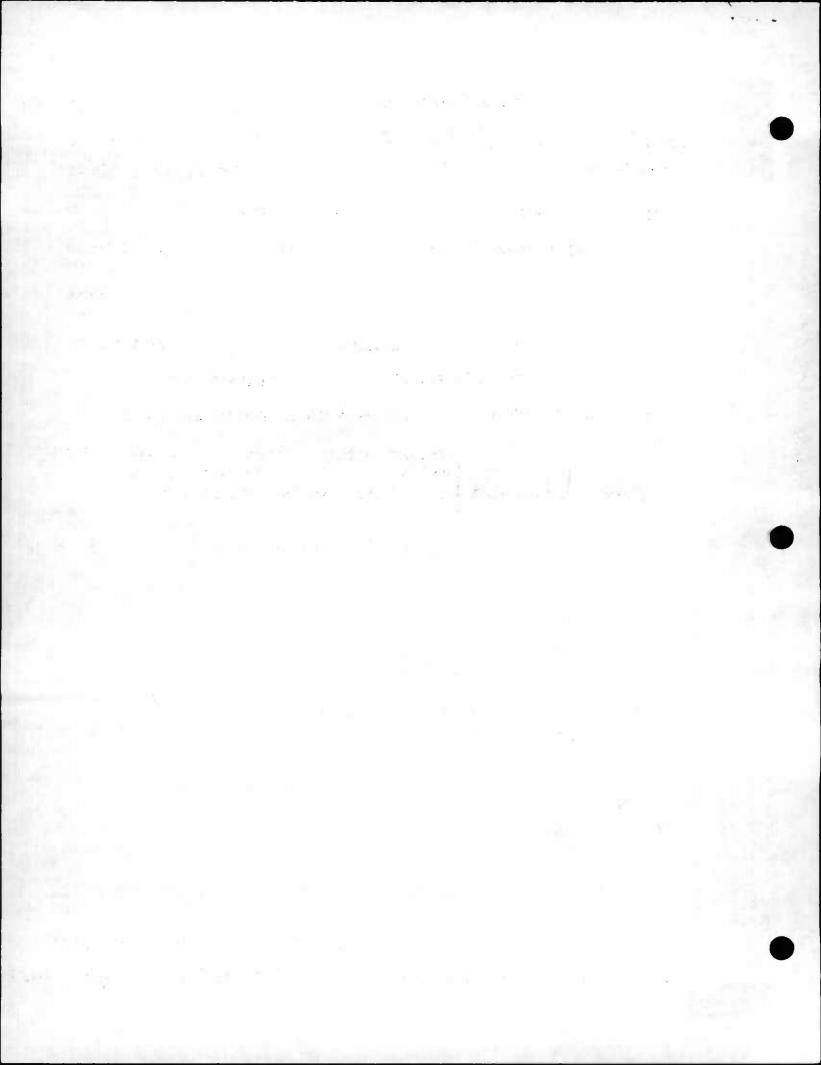
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State Registrar 30 Name and address of person who completed adjust

31. Date filed (Month, Day, Year)



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	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Frank Henry McGrath, Jr.						Reg. No. 2. Dete of Deeth Month Dey Yeer July 27 1998 3/09 P.				
A)	Examin Funeral Director	ier	212-34-4950	Re Hospi	TIO	en lek irithday) If Under 1 Year Yrs. Months Deys	Date of Birth (Month, Dey, ar. 2,	MORE Birthplece (Stete or Foreign Country) Texas					
Mandand	Maryland a-f show	tor	Usual Residence of Decedent 10e. Stete 10b. County Md.	N/A	10c. City, To	wn or Location Bali	timore City	7 -		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
d 21215-0020 filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or Hema 23a or 28a-f show ont, the Medical Examinet must be notified at	i Director	10e. Street end Number 610	3 Fairdel <i>F</i>	lvenue	10f. Zip Code	21206	10	g. Citizen of Whe	States				
	by Funeral	11. Maritel Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces	2. Wes Decedent Ever in U,S. Armed Forces? 1 Xi Yes 2 □ No Peace- 1 Yes 2 Xi No			y Yes or No- can, etc.)						
21215-0020	ene. then "neture	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grede completed) College (1-4or	16	e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire Accountant	petion e during most of working ed)	1111111111	6b. Kind of Busin				
an an	od be de	To Be Co	17. Fether's Name (First, Middle, L	Frank H.	Frank H.McGrath, Sr		18. Mother's Neme (First, Midd Benita Sa						
ž è	alth and I		19a. Informant's Name/Reletionsh Rita A. McGrath		19	6103 Fairde			City or Town, Ste				
more,	out of Haden		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp		e cemet	of Disposition (Neme of ery, cremetory or other ple	ece)	Date 2	Oc. Location - Cit	y or Town, Stete			
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Box.	ed for u	sician	Part II. Other significant condition	s contributing to death	but not resulting	in the underlying cause g	iven in Pert I.	23b. Dld tot	pacco use contri	bute to the cause of death?			
P. P.O	igned by the a	y Phy	Chronic ob.	STRUCTIO	e Pul	monARY	Disease	1 □ Ye	• 21 No 3	☐ Probably 4☐ Unknown			
I Records, P.O. Box 687	has been sig	Completed by Physician/Medic		RIAL FIL				24a. Wes er perform	led?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?			
tal F		Be Cor	25. Wes case referred to medical				26. Plece of Deeth (1 ☐ Ye	<i>J</i> .	1 Yes 2 No			
DIVISION Of VITAI Re- or mending Physician: The lav after each. Othercor: Atter this certificate has string the funeral director, page 2	Medical Certification: To E	exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investig 3 Suicide 6 Could neterming	ot be See Sleep of t	jury 28b ay Year)	. Time of lnjury 28c. Injury	ury et 28 ork?	d. Describe ho	sidenca 6 □Other (Specify) how injury occurred (Street end Number or Rural Route Number,					
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Us	0 1 kg		29b. Signature and title of certifier	20. Me	dical 1	Rosident RD	188910]	Tuly 2	7.1998			
	Sta Registr		30. Name and address of person v DR. PROSPER 31. Date filed (Month, Day, Year)	the completed cause of SANChez 291998 32. Regis	9000 F	(Type, Print) RANKlin Se	CUARG DR.	BAITI	more, M	ARYLAND 2123			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Yae 1040 AM Ethan Kyan 1998 m 001 c Jula 4c. County of Deeth 4e Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death Hospital St. Agnes 5. Social Security Number Baltimore If Under 24 Hrs. 8. Dete of Birth Hours Min, (Month, Dey, Year) if Under 1 Year 9. Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) 10M 20 F Months July 22,1998 Maryland None Usuel Residence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 P No 10g. Citizen of Whet Country? 10e. Street and Number 608 454 Glen 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Evar In U.S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -o-infant -0 _ 0 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) C. C Christine Maier 0. MUDTE Inomas 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 6084 Rock Glen Drive, Elkridge, Md. 21075 a of Disposition (Name of Date 20c. Location City or Town, Stete Thomas Moore - father 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/28/98 Elkridge, Md. Meadowridge Mem. Park 22. Nama and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc Laura A. Dexter 7250 Washington Blvd., Elkridge, Md. 21075 se, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximete Intervel Between Onset end Deeth PULMONARY FAILURE immediate Ceuse (Finel 15 HOURS disease or condition resulting in deeth) RESPIRATORY SYN DROME Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) 29 HOURS PREMATURITY Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ASPHYXIA PERINATAL 24b. Ware autopsy findings available prior to completion of cause of deeth? INTRAVENTRICULAR HEMORRHAGE, GRADE IV 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 Tes 2 DNo

Physician /Medical Examiner

Physician

/Medical

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permit. Pages 1 and 2 should be filled within 72 l Department of Health and Mental Hygiane. Important II fam 27 is marked other than "net

Baltimore.

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NAME Ethan Ryan

Physician/Medical Examiner ð

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within 24 hours after death To the Funeral Director: / completaly filled in by the

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or Attending Physician:

26. Plece of Deeth (Check only one)

25.	Wes case examiner?		to	medical
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07	11	D 41.		

5 Pending investigation

6 Could not be determined

Hospitel: 1 Inpatient 28e. Dete of injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Naturel

2 Accident

3 Suicida

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier

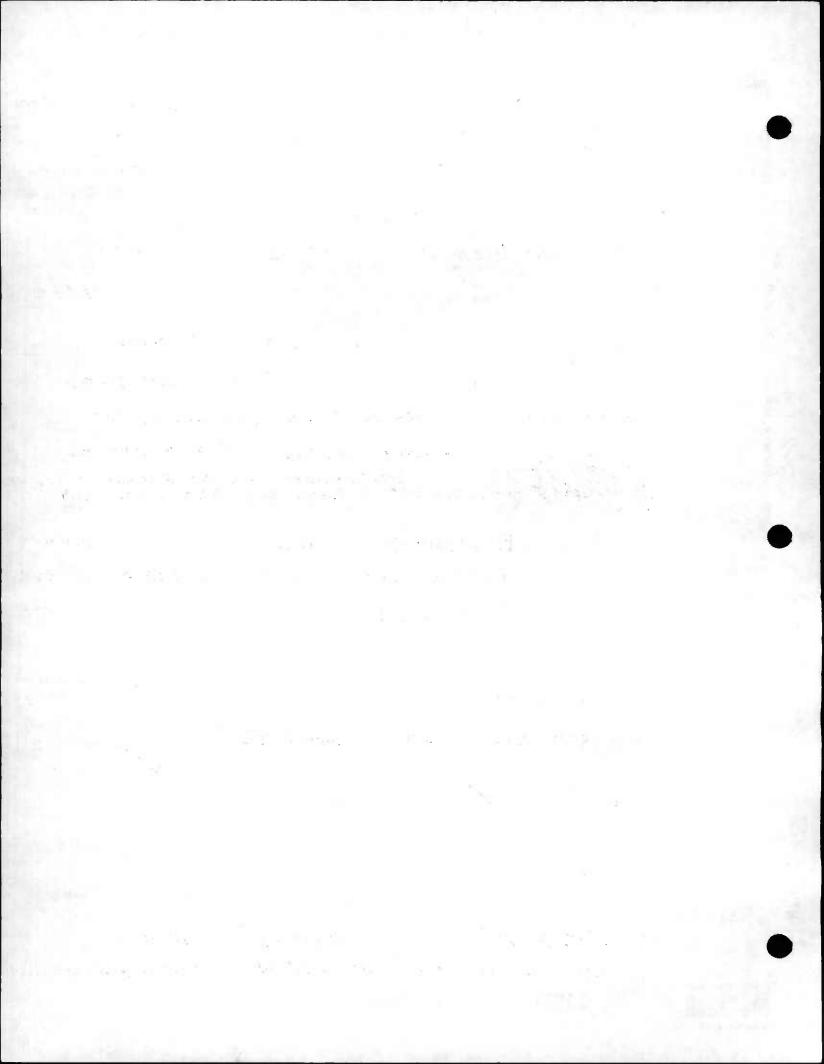
29c. License number 14955 29d. Date signed (Month, Day, Year)

and

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 900 CATON AVE, BALTIMORE, MARYLAND 21229 SANTOS

State Registrar 32. Registrar Signeture

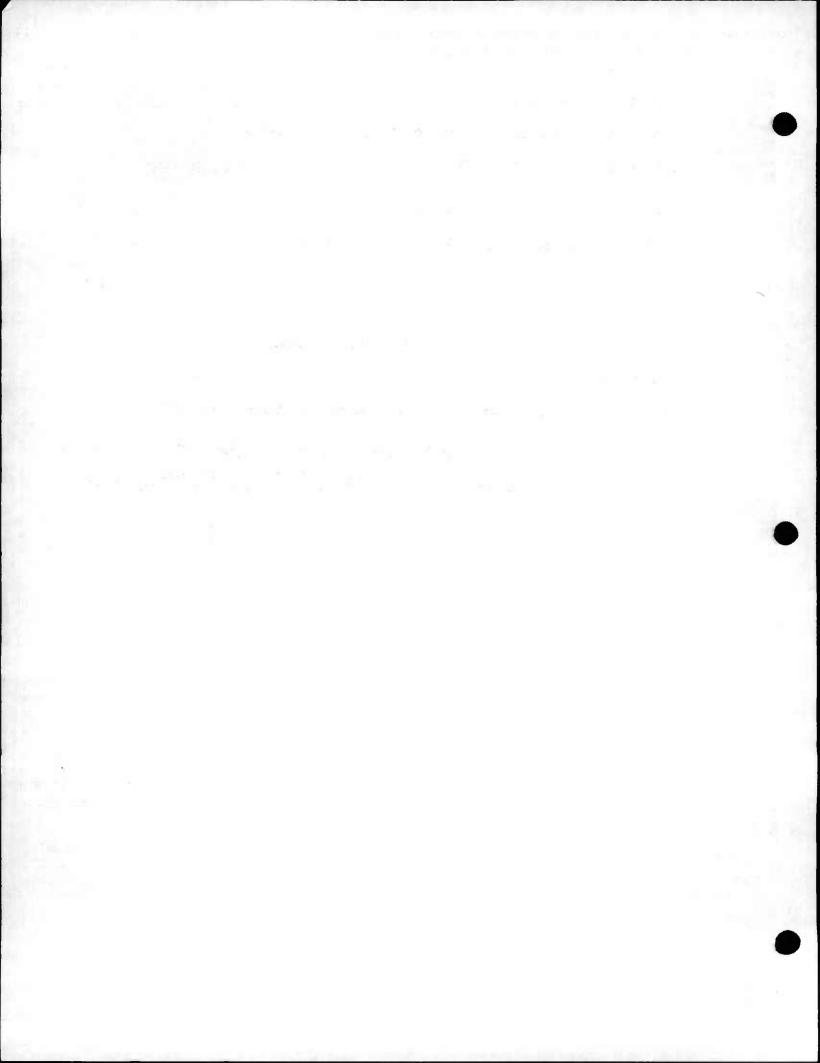
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State of Maryland / Department of Health and Mental Hygiene 98 23 170

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Physicia		1. Decedant's Nama (First, Middla, L							2. Data of De	ath Day	Yaar	3. Time of Death									
/Medical Examiner		EDINA M. MILLIGAN 4b. City, Town, or Location of Death										11:17 A									
		STELLA MARIS HOSPICE AT MERCY HOSPITAL BALTIMORE																			
Funeral Director		5. Social Sacurity Number 6. 212-05-1664 Usual Rasidanca of Decedent	Sax 7. A 1□ M 257 F	iga (In yrs. last bii 88	Yrs. If Un Month	dar 1 Year ns Deys	If Undar Hours	Min.	8. Data of Bird (Month, Da Feb. 1	2 1910	9. Birthr Cour Mary	placa (Stata or Fore									
Department of Health and Mental Hygiens, Important: If Items 23s or 28s-f show Important: If Item 27 is marked other than "natural, or items 23s or 28s-f show any loury or other traumetic event, its Medical Example, must be notified at once. To Be Completed by Finneral Director		10a. State 10b. County	ı/a	10c. City, Tow Balti							1	10d. Insida City Lin 1 X Yas 2 □									
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 1998 July 17 **Physician** John Francis Middleton 1006 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** The Kent and Queen Anne's Hospital, Inc. Chestertown Kent 7. Aga (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Months Days Hours Min. January 3 1941 5. Sociel Security Number 9. Birthplace (State or Foreign **Funeral** 1,□M 2□F WASH DC 578-54-0945 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 HNo Director Baltimore Co. Parkville or 28a-f 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? or items 23a 9810 Britinay Lane Funeral 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 T Married 1 Yes 2 No If Yes, Give Yaar or Datas: Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced natural', Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Self-employed-President Middleton & Meads Corp marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meidan Surneme) Be vin end Mental I Pages 1 end 2 should be Blair T Middleton Mary Virginia Groves 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Patricia Middleton Health em 27 is 9810 Britinay Lane, Parkville, MD 21234 other Item 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any injury or on 1 ☐ Burial 2 Cremation 3 ☐ Removal from State MetroCrematory 4 ☐ Donetion 5 ☐ Other (Specify) July22,98 Catonsville, MD 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Charlton Funeral Home 23e. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate shock, or heart feilure. List only one cause on each line. Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical Examiner Examiner the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In death) Lest Due to (or as e consequence of) the buriel-tre ate hes been signed by the ettending physician page 2 should be detached for use as the burie Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yae 2 ☐ No py 24b. Wera eutopsy findings eveilable prior to Completed 24a. Was an autopsy completion of cause of deeth? certificate hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA L this the funeral 27. Manrier of Death 1 Naturel 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation Injury death. 1 Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide

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Baltimore, Maryland 21215-0020

Box 68760.

State

Medicai

29a. Certifier

(Check only one) 29b. Signature and title

Day, Year)

291998

Registrar

32. Registrar's Signature wha Davidson

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated.

29c. Licensa number

29d. Date signed (Month, Dey, Yeer)

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UNKNOWN

WHITE

10d. Inside City Limits 1 X Yes 2 ☐ No

Approximete Intervel Between Onset and Death

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 X Yes 2 No

JULY 06, 1998

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

State of Manuand / Department of Health and Mental Hygiene

ROBERT GRI

FFIIH MELVIN	Certificate of Death		. No. 9	3 2	317
1. Decedent's Name (First, Middle, Las	st)	2. Dete of Deeth Month	Day	Year	3. Time of

r 28a-f

Hygiene. Wher then 20 Monta Pages 1 and 2 should and in Health i Department of I ĕ

Maryland 21215-0020

Baltimore,

Physician /Medical **Examiner**

that tha daath certificate be executed physician and the burief-trans P.O. Box 68760, for use as signed by the a Records, page 2 certificate Division of Vital or Attending Physician: director Aftar this funeral eftar deeth. Director: Aft à

Physicia MELVIN JULY 05, 1998

4b. City, Town, or Location of Death 4c. County of Death GRIFFITH /Medical 4e Fecility Name (If not institution, give street and number) Examiner 120 EAST AYLESBURY AVENUE TIMONIUM BALTIMORE COUNTY 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Hours 1⊠M 2□ F 39 rs. 1/25/1959 **Director** UNKNOWN Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Directo MARYLAND BALTIMORE COUNTY OWINGS MILLS 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number r than "natural", or items 23a or the Medical Examiner must be. 1 SHASTA CIRCLE APT.F UNITED STATES Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indien 11. Marital Status UNKNOWN Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: UNKNOWN 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: À 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN TELEMARKETING UNKNOWN HOME IMPROVEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be UNKNOWN 10 UNKNOWN 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) UNKNOWN UNKNOWN 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☒ Other (Specify) in State Signature of Eureral Service Licensee Ronald S. Wade 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 Part1. Enter the disease, of complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (or as a Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Physician/Medicai Due to (or es a consequence of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown by 24e. Wes en eutopsy Completed 1 X Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE 1 XYes 2 No 2 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month: Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury Certification: few of to Injury 1 ☐ Naturel 5 Pending tore of 1 Yes Scation (Street and Number or Rurel Route Number, investigation UNK 2 N Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 24 hours eftar re Funeral Direction Dietaly filled in b 4 Homicide ylesburg KO 20 itome 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es steted.

**Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. Medicai To the Hosp within 24 ho To the Fune completaly fi one) Signature apt title of certifier 29b. 29c. License number 29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

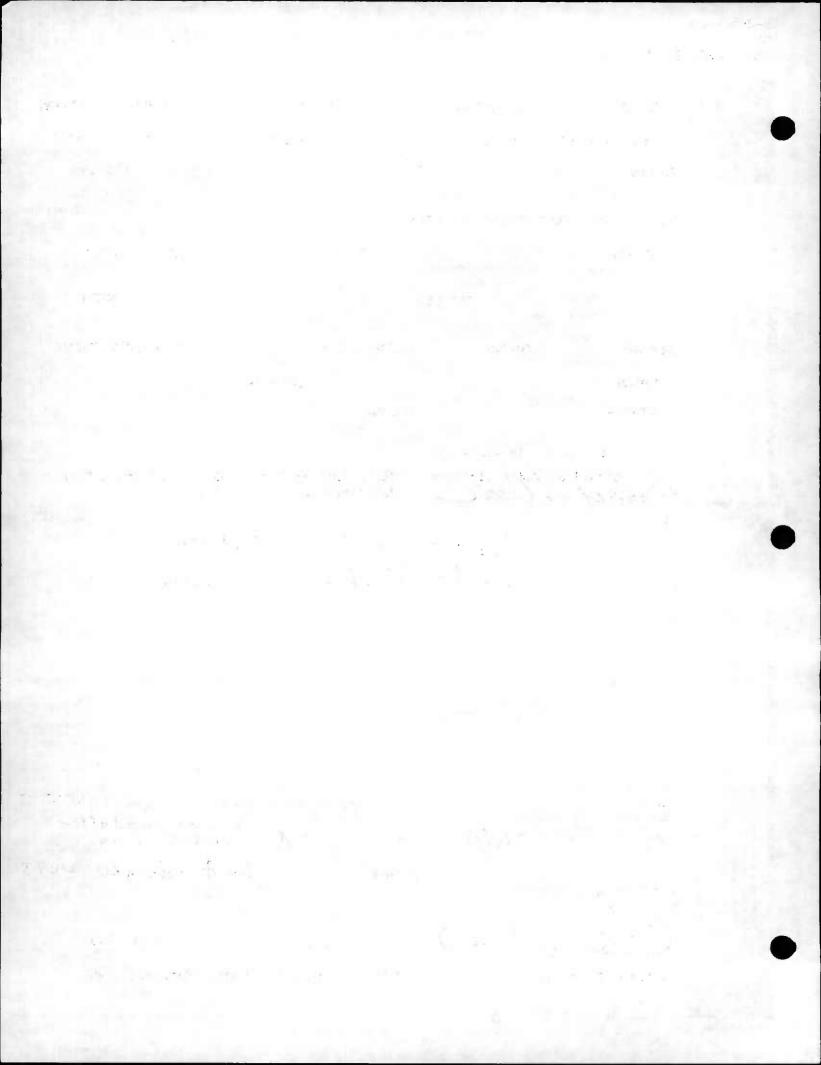
32. Registrar's Signeture

whia Davidson-Randale

J. Laron Locke M.D.

31. Dete filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Catherine P. McCoy July 27, 1998 7:30a.m. /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** n/a Baltimore 3117 Belmont Avenue If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
Oct. 2, 1 If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 35 F 61 Yrs 216-32-7144 1936 Md. Director Usuai Residence of Decedent pernit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumetic event, the Medical Example must be notified at 9006s. 10a, State Md. 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore n/a XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 3117 Belmont Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes Sty No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ₩Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Shapairo & Olander Elementary/Secondary (0-12) College (1-4or 5+) Law Firm Word Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Catherine Collins David Johns Sr. 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Michael McCoy 3117 Belmont Avenue Baltimore, Md. 21216 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Baltimore, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Servica Licanses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 nutter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) MATOSTATIC BREAST CONCER. /Medical Examiner Due to (or as a consequenca of): Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): Physician/Medical Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Parl II. Other significant conditions contributing to death but not resulting in the underlying cause given in Parl I. 1 | Yes 2 | No 3 | Probably 4 D Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 2 No 1∏ Yes 1 □Yes 2□No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Manger of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Yeer) 28c. Injury et Work? 28b. Time of 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0020

signed by the e should t certificate has t director, page 2 s Hospital or Attending Physician: this After To the Hospital or Attending within 24 hours after death.

—To the Funeral Director: Afte completely filled in by the fun

State

edical

29e. Certifier

(Check only one)

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

Registrar

Johns Hopeins ONWOOS! CTA 600 N. WOLFE St. MS FETTINOMS 32. Begistrar's Signeture

Navidson—Randelle

end menner stated.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

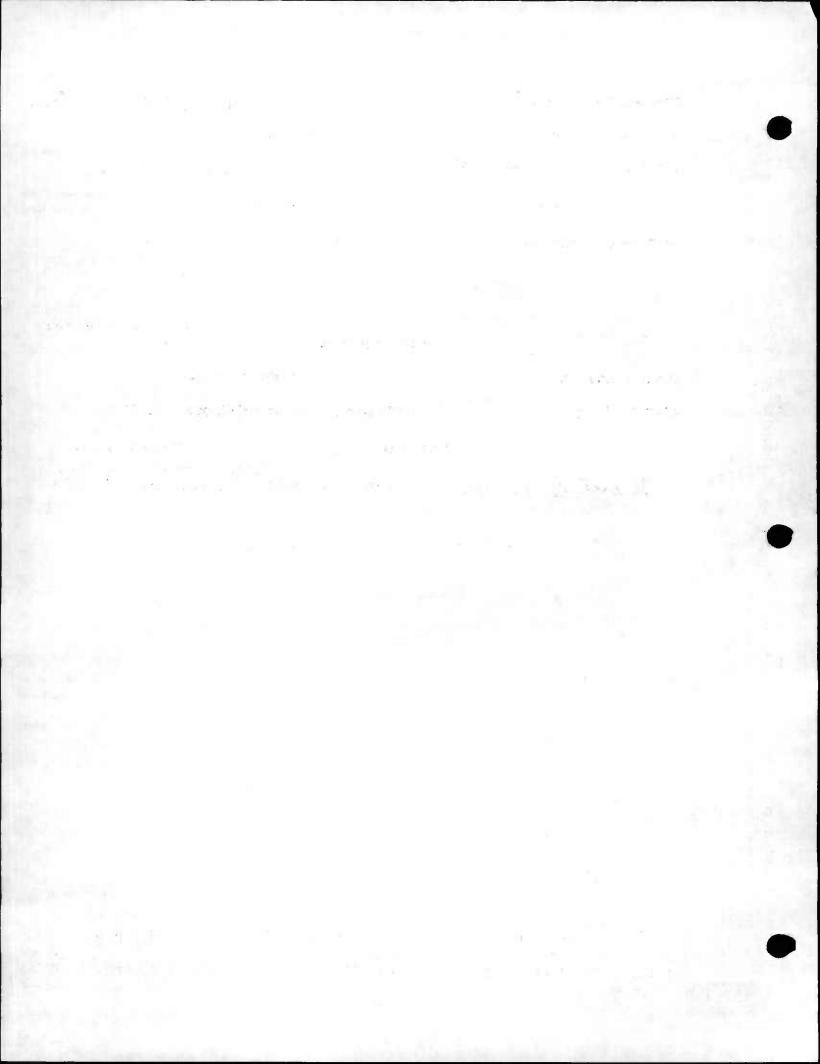
29c. License number

D18320.

29d. Date signed (Month, Dey, Yeer)

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Marsh

Physician /Medical Examiner

Funeral Director

the Meryland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Deperment of Heelh and Mental Hygiane. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumstic event, the Medical Exempter matter notified and injury or other traumstic event, the Medical Exempter.

Baitimore, Maryland 21215-0020

Physician /Medical

Examiner ed by the ettending physician end deteched for use as the buriel-transit requires that the deeth certificete be executed signed by Records, peeu Wel ern page 2 After this certificate hes To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

P.O. Box 68760.

Division of Vitai

Patricia July 1998 21 12:50 PM 4a. Fecility Neme (If not institution, give street end numbar) 4b. City, Town, or Location of Daath 4c. County of Daath 10805 Vista Road Columbia Howard If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 □ M 2 1 F Months 219-28-4807 66 Oct. 15, 1931 Usual Residence of Decadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10805 Vista Road 21044 Funeral 12. Wes Decedant Evar In U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, atc. 1 ☐ Yes 2♥ No If Yes, Give Yeer or Detas: 1 ☐ Never Merriad 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be Leta Foard Munroe Marion Blaine French 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sewell R. Marsh (Husband) 10805 Vista Road, Columbia, MD 21044 20b. Plece of Disposition (Name of cematery, crametory or other place) JulyDate 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ▼ Burial 2 □ Cremetion 3 □ Removel from Steta 4 □ Donation 5 □ Othar (Specify) Crestlawn Mem. Gardens 23, 1998 Marriottsville, MD 22. Neme end Addrass of Fecility 21. Signature of Funerel Sarvica Licansee Witzke Funeral Homes, Inc. Landa X demmer 21045 5555 Twin Knolls Rd. Columbia, MD 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not anter tha mode of dying, such es cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. Immediete Ceuse (Final disease or condition resulting In deeth) Melanoma metastatic to Truer + long lonally Due to (or es e consequença of) Examiner Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consaquence of): Physician/Medical that initiated events resulting In daeth) Last Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Anorgain I cacheria þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy Aspiration PAROMONIA, Invadice 1 ☐ Yes 2 No 1 Yas 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NResidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 29a. Certifier 15 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medicat Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner steted.

29c. Licanse number

11065 Little Raturent Parkury, Colombia, MD

030573

29d. Dete signed (Month, Dey, Year)

7-22-98

State Registrar

31. Date filed (Month, Day, Year)

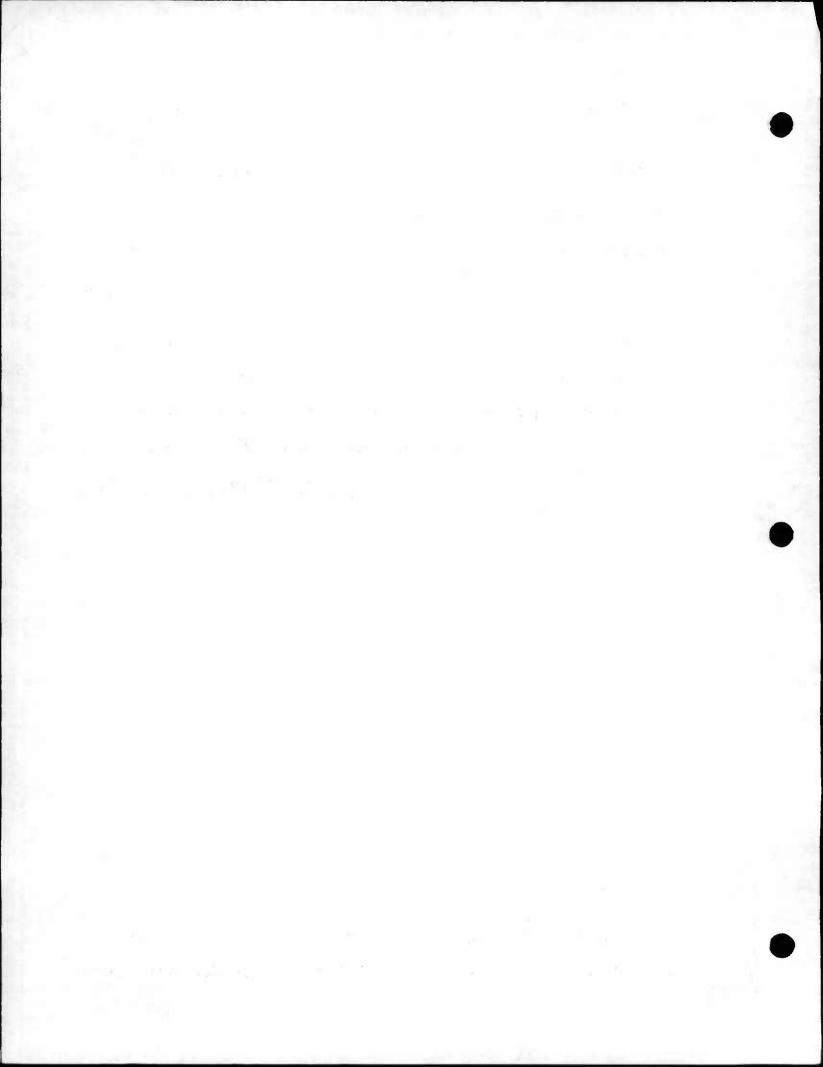
Mistind,

29b. Signature and title of certifiar

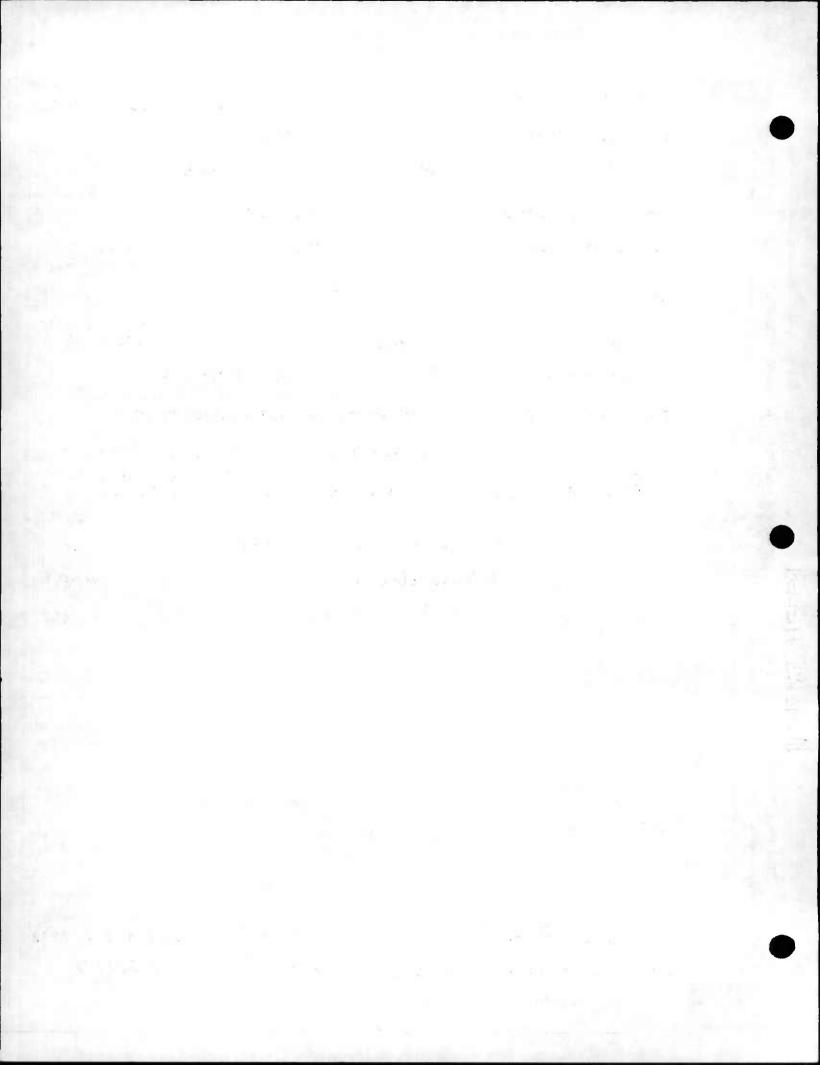
32. Registrar's Signature I hia Davidson-Randalle

MD

30. Name end eddrass of person who completed cause of deeth (ttem 23e) (Type, Print)



				•	Certificat		Death		Reg. No.	3 2	3 75
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	/Medical Examiner	4e Facility Neme (If not institution, g	4b. City, Town, or Lo				1.ZUAN				
		ST. ELIZABETH'S HOME BALTI									
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	More More	Usuel Residance of Decedent 10a. State 10b. County 10c. City, Town or Location									d. Insida City Limits
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lary	s mar s mar	19a. Informant's Name/Ralationship	(Type, Print)	19b.	. Mailing Addrass	(Stree	t and Number or Rura	l Routa Numb	er, City or Town,	Stata, Zip	Coda)
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Saltimore,	W 75	20a. Mathod of Disposition 1 X Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec			Disposition (Nary, crematory or o			Data 7/29/98	20c. Location		
W Ball	permit. Pege Department of Important: If any injury or phice.	21. Signeture of Funeral Service Livensee 22. Name end Address of Fecility WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD									
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	Physician /Medical	Immediata Causa (Final disaasa or condition a Congestive Heart failure									Onsat and Daeth
_ 10	Examiner	rasulting in death)		Dua to (or as a d	consequance of):		ME				
J	executed in end idel-transit	Sequentially list conditions Dua to (or as a consequence of):									10h1
10°,	e exection enclared tra	Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or Injury thet initiated avants	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Diabetes Mellits								1041
HE x 68760	entificate be executed sing physician end se es the buriel-transit	rasulting in daath) Last	U	Oua to (or as a c	consequanca of):						
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P.O.	ss that the death certing gned by the ettending be deteched for use by Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown		
Mey Records,	been si should							24a. Was	s en eutopsy ormed?	cor	tra autopsy findings bilabla prior to nplation of causa daath?
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of V	hysic his ce al dire	1 ☐ Yas 2 ☑ No	Hospital: 1 ☐ Inpatiar		tpatiant 3 DC	DA			idanca 6 □Ott		1)
ouo	ding P. After t	27. Manner of Daath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident invastigati	28a. Date of Injury (Month, Day	Year) 28b. T	Firma of 2 njury M	8c. Inju Wo	iry at ork?] Yas 2 □ No	28d. Describe	how injury occur	rred	
Division of Vital	tal or Attanding P Is after death. al Director: After t led in by the funera Certification:	2 Accidant invastigati 3 Suicida 6 Could not 4 Homicida datarmine	be Ope Place of Inju	ry - At homa, fa . (Spacify)				28f. Location City or To	(Straat and Num wn, Steta)	ber or Rura	l Routa Numbar,
	To the Hospital or Attanding Physician: with 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Cartifiar 1 Certifying F (Check only one)	hysician: To the best of aminar: On the basis of and mannar state	axamination and	, daath occurred d/or invastigation	at tha t , in my	ima, data and place, opinion, deeth occurr	end due to the ed at tha tima	causa(s) and m , data and placa,	annar es st and dua to	ated. tha ceuse(s)
	vithin To the comple	29b. Signatura and titla of certifiar	Anuel		290	D. Lican	30/3	2	29d. Date signs	ad (Month, i	Day, Year)
	5	30. Nama and addrass of person who		eath (Itam 23a) ((Type, Print)	~	3013 T	2AT	MA	2127	7
	State			r's Signatura	N.Ch.10	, _		1-1-1		, – ,	
1.01	State Registrar	31. Dete filed (Month, Day, Year)	98 Julia	r's Signatura	Mandelle						



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1:30 PM Electa D. Ney 27 1998 July 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Manor Care Ruxton Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 10,1904 Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Days 1 ☐ M 2 👿 F 93 Yrs 215 50 7130 Minnesota Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Maryland n/a Lutherville 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11151 Falls Rd 21093 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 12 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) (unknown) Davis Elizabeth Smith 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jan D. Maslin / Niece 11151 Falls Rd., Lutherville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/28/98 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 Xolumann 23a. Part1. Enir the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stro he Immediate Cause (Final disease or condition resulting in death) ros Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be assecuted P.O. Box 68760, Division of Vital Records,

Physician/Medical Examiner inding physician and usa as the buriel-transit p Completed Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

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permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health end Mental Hygiene.
Important: If Item 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Modes Examinat matter notified at any injury or other traumatic event, the Modes Examinat matter notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

signed by the a been sig is certificate hes t director, pega 2 s al or Attending Physician: The safter deeth.
Il Director: After this certificated in by the funeral director, pe To the Hospital or within 24 hours aft To the Funeral Di complately filled in

edicai

29a. Certifier

29b. Signature and title of certifie

State Registrar

29c. License number

1 ☑ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piace, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

291998

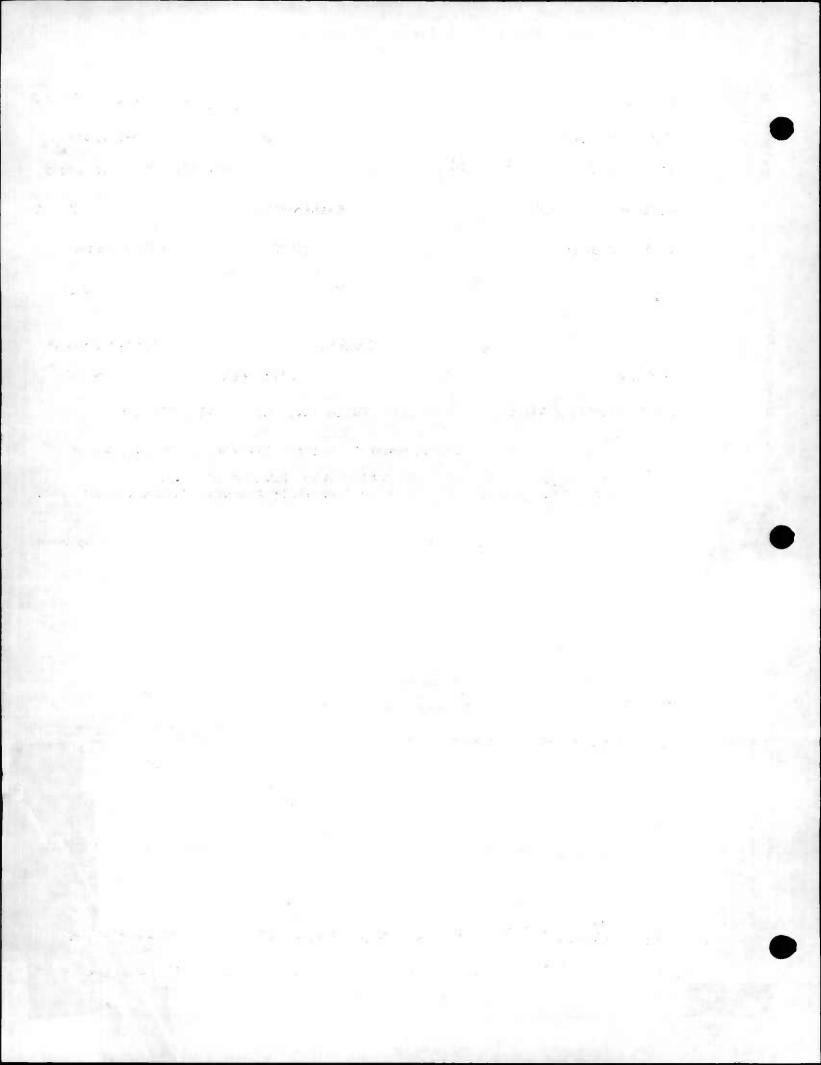
Milonnen 500 W. University Villiam MD

31. Date filed (Month, Dey, Year)

U

wha Davidson Randall 32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth PARKS Dey Month **Physician** MAE 2026 Hrs JULY EZZIE 1998 27 /Medical 4b. City, Town, or Location of Daeth 4c. County of Deeth 4a Facility Nama (If not institution, give street end number) Examiner HOSPITAL 12 ANDAUSTOWN BALTIMORE NORTH WEST If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. NOW 1997, Year 1912 Birthplece (State or Foreign Country)
 NTC 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 20 F 85 Yrs NC Director 246-09-1579 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits od Mental Hygiena. marked other then "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at RANDALLSTOWN N/A Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5627 OLD COURT RD 21133 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14 Bace - American Indian. 11. Marital Stetus Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Dopartment of Health and Mental Hygiana. Proportant: if leen 27 is natived other than "natural", or the any injury or other traumatic event the Manager. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: BLACK Specify: þ 3 Widowed 4 X Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) Elamantary/Secondary (0-12) College (1-4or 5+) 5th N/A PRESSER DRY CLEANERS 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Nema (First, Middle, Last) Be IDA ELLIS 2 AMOS BATTS 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Raletionship (Typa, Print) 3404 BRENDAN AVE BALTO, MD 21213 IDA MOORE 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State KING MEMORIAL PARK 8-1-98 BALTO, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fyneral Service Licensee 22. Name end Address of FecilityBETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Dua to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the causa of death? 3 Probably ∲@Unknown 1 Yes 2 No þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 2 000 1 Yes 2 No 1 ☐ Yes Be 25. Wes cese raferred to medicel examiner? 26. Piece of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Depatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

attending physician and I for use as the bunal-transit The law requires that the death certificate be executed P.O. Box 68760, signed by the a Division of Vital Records, r this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p. Medical

Baltimore, Maryland 21215-0020

State Registrar 29b. Signature end title of certifier

NC Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and mennar es stetad.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar statad. 29c. License number

29d. Date signed (Month, Day, Year)

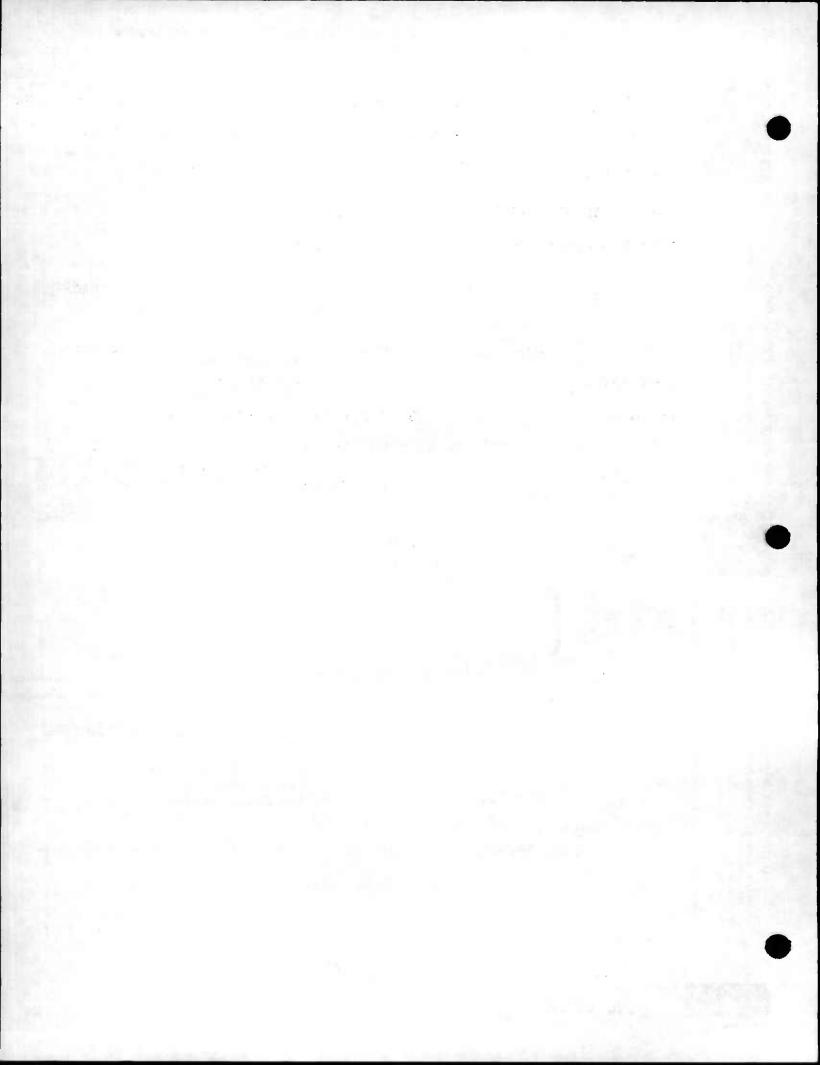
30. Name end addrass of person who completed ceuse of deeth (Item 23e) (Type, Print)

BALTO . RAVI MD, NHC

31. Dete filed (Month, Day, Year) 291998

29a. Certifier

39 Registrar's Signeture Davidson-Randelle



606 nmm NDSIN

hie Davidson-Mandale

BALT. 21225

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State

Registrar

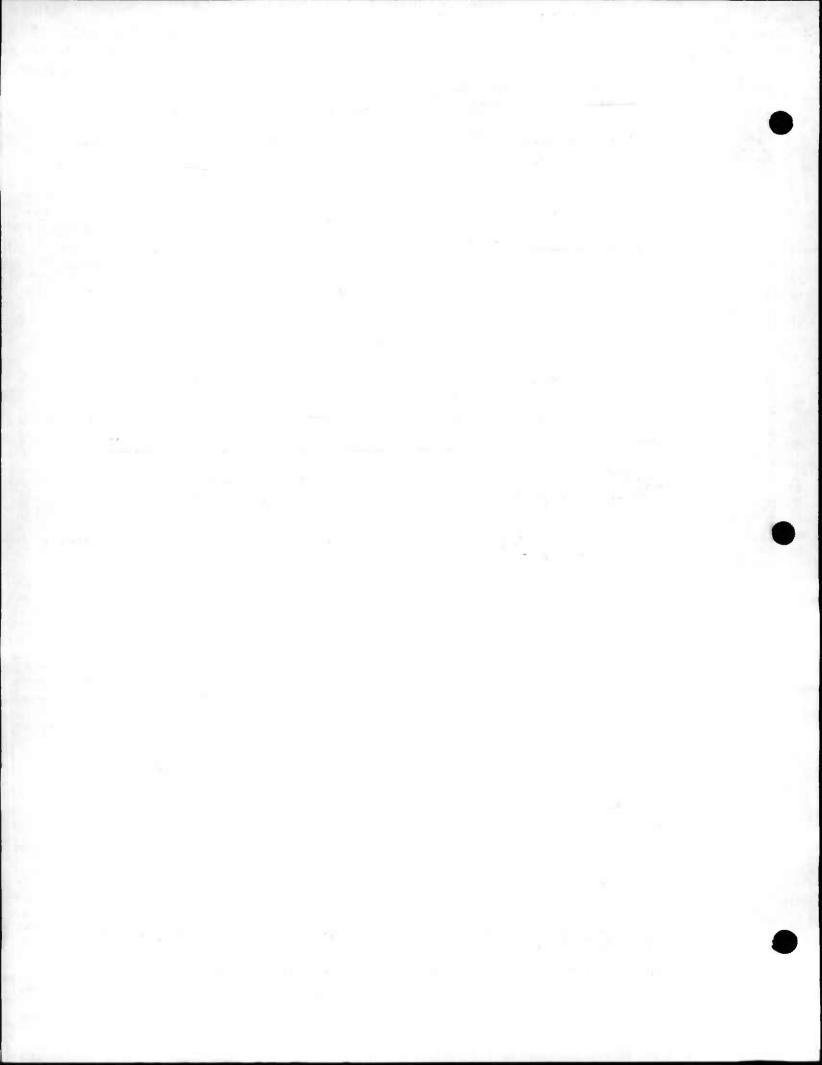
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

291998

32. Registra Signature

PATEL, PRATEULL

31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Quinn **Physician** OTRICK /Medical 4b. City, Town, or Location of Peath 4a Facility Name (If not institution, give stre 4c. County of Deeth Examiner Dal TMOVE Hospita ohus If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birt (Month, Day, Year) Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days Hours Months 10 M 20 F Yrs. Director None 10 July 14, 1998 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examines must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Howard County Elkridge 10f. Zin Code 10g. Citizen of What Country? 10e Street end Number 6319 Troy Court 21075 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 Child 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Kevin Patrick Quinn (Father) Jennifer Paige Haberkorn (Mother 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kevin Patrick Quinn /Father 6319 Troy Court Elkridge, Md. 21075 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Glen Haven Memorial Park 7/27/98 Glen Burnie, Maryland 21. Signeture of Funerel Service Licensee Ecker McCully-Polyniak Funeral Home Kevin E. 237 E. Patapsco Ave. Balto., Md. 21225 Approximate Intervel Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner The law raquiras that the death certificata be executed attending physician and for usa as tha burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): been signed by the a should be datached Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Hemorrhe 1 Yes 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Failure Completed 24a. Was en eutopsy performed? 28 10 1 Yes after death.

Director: After this cartifica 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 27. Manner of Deeth 1 Neturel 2 Accident 28e. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and menner es stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end title of certifier

th (Item 23e) (Type, Frint)

32. Registrar's Signeture

The Condoon-Hands

State Registrar tame end address of ferson who complete

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291998

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31. Date filed (Month, Day, Year)

JUL

The same, the first of the firs

10d. Inside City Limits 1 Ves 2 □ No 10g. Citizen of What Country? USA 14. Raca - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Genesis Nursing Home 18. Mother's Name (First, Middle, Malden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Carroll Co, Md 21771 20c. Location - City or Town, State 7-28-98 Randallstown, Md Baltimore, Md 21215 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evaileble prior to completion of cause of death? 24e. Wes en autopsy 1 Yes 2 No 1 Yes 2□ No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year)
FOUND 7-24-98
FOUND 8:00M 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No UNKNOWN 2 Accident 6 🖾 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4511 SPRINGDALE AVENUE 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide FOUND: HOME BALTIMORE CITY, MD 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and manner es stated.
2 Hedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. Medical 29d. Date signed (Month, Dey, Year) 29b. Signature a the of certifier 29c. License number 25, 1998 JULY O.C.M.E 30. Name and ed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Day

Year

0855 AM

Birthplace (State or Foreign Country)

Md

1998

4c. County of Death

State Registrar

31, Date filed (Mon

Day.

JUL

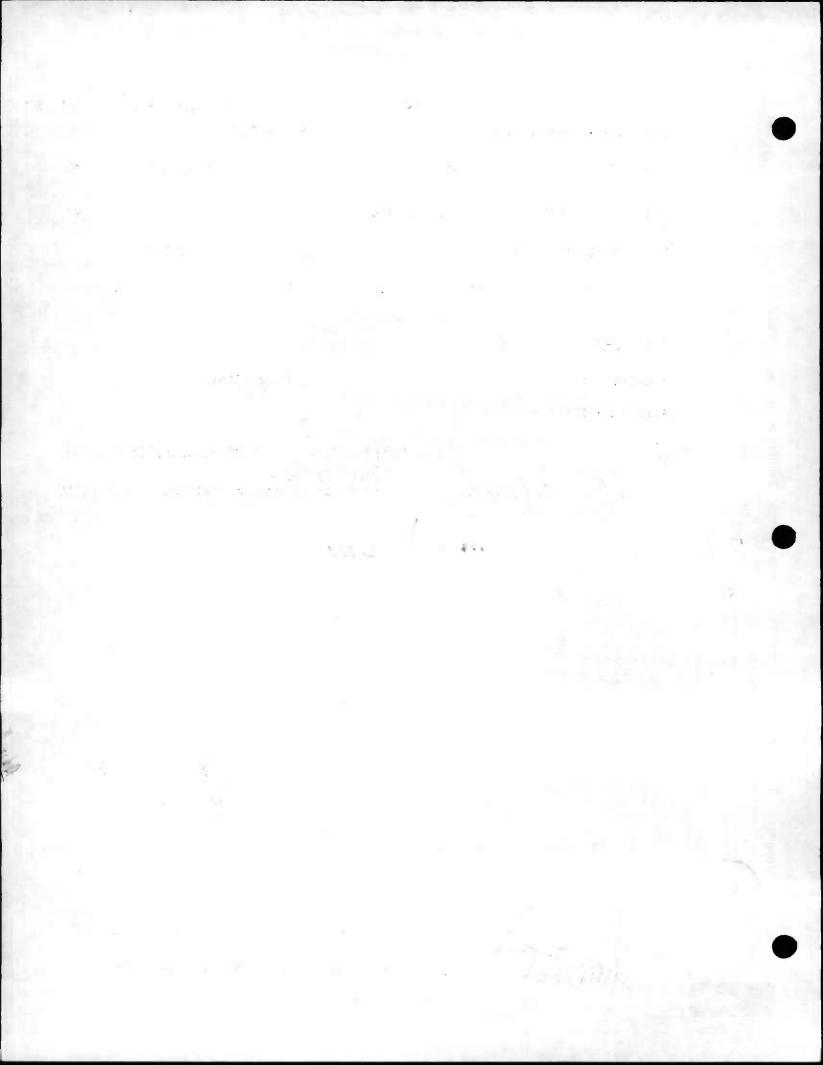
291999

32. Registrer's Signature

who Drivers

After

stor:



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Kathryn Corinne Rausch

Physician · /Medical Examiner

Funeral Director

Deys Hours Months 91 Yrs. 218-01-7757 Usual Residence of Decedent 10b County 10c. City. Town or Location ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Event entrat be notified at Maryland Anne Arundel Pasadena Director 10e. Street end Number 10f. Zip Code 1082 Trails End Road 21122 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health end Mental Hygiane. If them 27 is merked other than "natural", or iter any injury or other traumatic event. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 17. Fether's Neme (First, Middle, Last) Be Amrhein Frederick 0 19e. Informent's Name/Relationship (Type, Print) Frederick C. Rausch Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licens **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Cardiopulmonary Examiner Examiner Bradycardia Wide Complex

Due to (or es e consequence of): been signed by the attending physician and should be detached for use as the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest P.O. Box 68760. Due to (or es e consequence of) Axtery Physician/Medical Aneurysm Nortic Poracic Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, þ Completed Atrial After this certificate Attending Physician: 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) exeminer? 1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Naturel saffer death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral D completaly filled 29a. Certifier Medical 29b. Signeture and title of gertife 29c. License number MD D32654 dress of person who completed cause of deeth (Item 23e) (Type, Print)

Serlemitsor

L. Da 2 9 1998

301 Hospital

1. Decedent's Name (First, Middle, Last) Month July 21,1998 6:25 p.m. 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. Yeer) Jan. 26,1907 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of Whet Country? U.S.A. 14. Race - American Indien, Bleck, White, etc. White Specify: 16b. Kind of Business/Industry Law Office Of Rome, Rome& Hamburger 18. Mother's Name (First, Middle, Meiden Surneme) Blanche Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1082 Trails End Road Pasadena, Maryland 21122 20c. Location - City or Town, Stete Dulaney Valley Cemetery July 24,1998 Timonium, Md. MCCUITy—Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 23a ant 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth 10 minutes years 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evalleble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Year) July 21, 1998

Drive, Glen Burnie, MO 21061

State Registrar

disk in general time in which the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Melvin Smith State of Maryland / Department of Health and Mental Hygiene Item 26 Film q761 7-29-98 rja per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 7 **Physician** 10:19am Melvin 23 98 D. Smith /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1000 E. 36th Street Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Yrs. Director 212-44-5711 50 11-08-47 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e. State pernit. Pagas 1 and 2 should be filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiana. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at another traumatic event, the Medical Examiner must be notified at another. XYes 2□No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 845 Benninghaus Road 21212 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Baltimore City Police Officier 12th Grade 33 Yrs. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Smith 2 Dorothy Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Fannie 845 Benninghaus Road Baltimore, Md. 21212 L. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Cemetery 07-30-98 Baltimore, MD e of Funeral Sarvica Lica 22. Name and Address of Facility Baltimore, Maryland 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** tmmediate Cause (Finat disease or condition resulting in death) Infarction /Medical Myocardia minutes Examiner Due to (or es e consequence of): Physician/Medical Examiner typer tension physician and s tha burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be axeci Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attanding p 23b. Did tobecco use contribute to the cause of death? been signed by tha a Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy ate has 2 No 1 ☐ Yes 1 ☐ Yes 2 No cartificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifice director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 18 (Other (Specify) on Scene 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funaral 27. Menner of Deeth 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Certification: 5 Pending investigation 1 DNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a, Certifier edical 29b. Signature and the opening 29d. Date signed (Month, Day, Year) 29c. Licansa numbar

30. Name an

State Registrar 31. Date filed (Month, Day, Year) JUL 291998

John

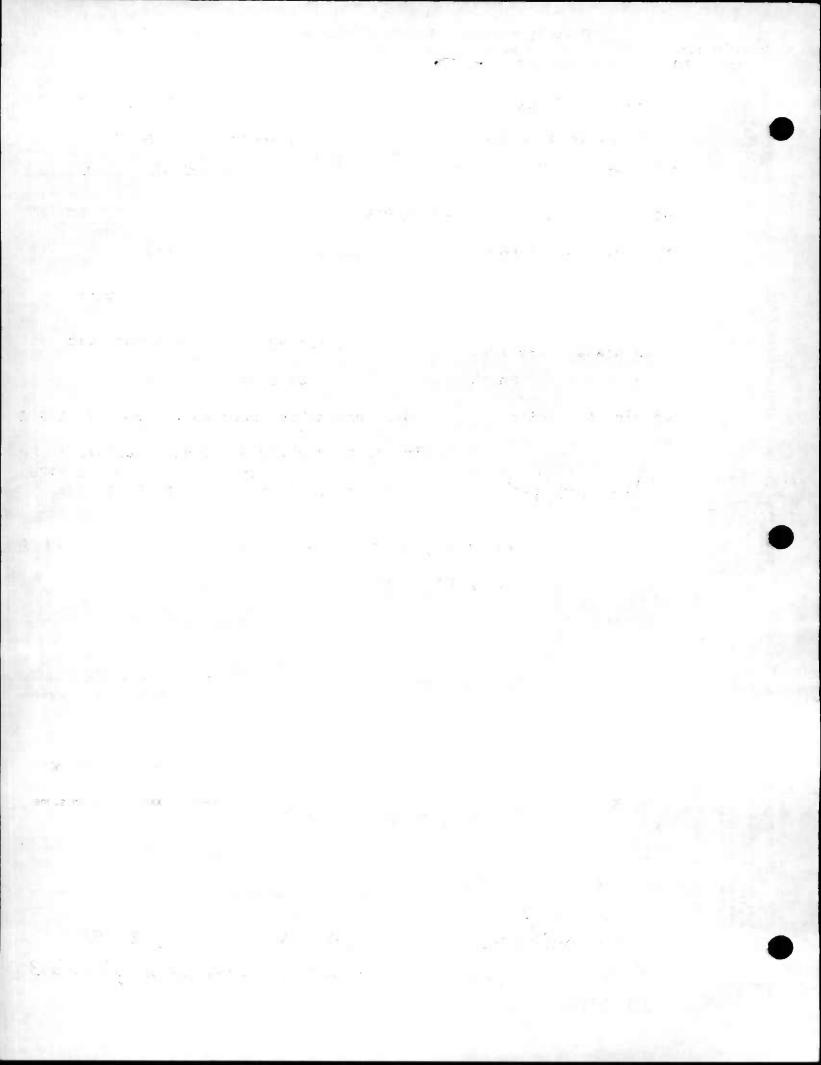
MD, 12 32. Registrar's Signature Filia Davidson

01

Rd#20 Lutherville, Maryland 21093

address of person who completed cause of death (Item 23a) (Type, Print)

10



State of Maryland / Department of Health and Mental Hygiene 9 8 9 3 1 8 3

					Certificate of	Death	Reg	ı. No.	
ı	Physici		1. Decedent's Name (First, Middle, Last)	Sastiful			2. Dete of Death Month JULY 26	Day Ye	3. Time of Death 0204 AM
	/Medio Examir		4a Facility Name (#4 of institution, give s 1201 WEST NORTH AV			4b. City, Town, or Local BALTIMORE		4c. County of C	Death
	Funeral Director		217-06-2000	M 2□ F 7. Age (In yrs. last bir	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	(ear) (9.	Birthplece (State or Foreign Country)
	Maryland -f show	tor	Usual Residenca of Decedent 10a. State 10b. County A A	10c. City, Tow	timore	-			10d. inside City Limits 1 Ves 2 □ No
	or 28a	Olrec	10e. Street and Number		10f. Zip Code		100	g. Citizen of Whe	t Country?
	23a	rai	•	ront St.	217	216		USA	
020	be filed within 72 hours after death with the Maryland in Hyglene. d other than "natural", or items 23a or 23a-f show event, the Medical Exam or roust be incitied at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2, Was Decedent Ever in U,S. Armed Forces? 1 Yes 2	13. Was Decedent of If Yes, specify Cub		cify Yes or No- Rican, etc.)		American Indien, White, etc. Black
21215-0020	med within 72 ho Hygiene. Ther than "natur int, the Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	e during most of workii ed)	16	Sb. Kind of Busin	ess/Industry
Maryland 2	culd be filed within Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last)	ayis. F	ionze ke	18. Mother's Name	1	aiden Sumame)	NS
_	1 and 2 shou Health and M em 27 le mer ther traumat	-	19a. Informant's Name/Relationship (Type)	01 - 11 - 11	Mailing Address (Stree		Route Number,	11	nte, Zip Code)
altimore,	1 de 1		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donetion 5 Other (Specify)	comoto	Disposition (Name of ry, crematory or other plants)	ace)	Date 20	Satto,	y or Town State
Balt	Department Department Important: any injury o		21. Signature of Funeral Service License	2 Herris	22 Name and Addr WM CN H300 (D)	pess of Facility Fu	were b	tone W	d. 21215
j.	Physician /Medical		23a. Pert . Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	eations that caused the death. Do e cause on each line.	not enter the mode of dy	ring, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
•	Examiner	er	disease or condition resulting In death)	DIVINITIO (or as a	sequence of):	would	\$		
,	axecuted n and ial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):			-	
x 68760	v requires that the death certificate be executed been signed by the attending physician and should be datached for use as the burial-transit	Medical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e	consequence of):				}
ê R	death ce e attandi		_ d.						
, P.O.	that the dened by the detached	by Physician	Part II. Other significant conditions cont	ributing to death but not resulting l	n the underlying cause g	iven in Pert I.			bute to the cause of death?
Records,	law requiras that as been signed b	Completed b					24a. Was an perform		24b. Were autopsy findings available prior to completion of cause of death?
	0 - 0	mo:					≯ OYes	2 □ No	1. Nes 2□ No
Vita		Be	25. Was case referred to medical examiner?		1 =	26. Plece of Death	(Check only one)	
01	his al di	To	Yes 2□ No	I am a management of the same	itpatient 3L DOA		me 5 Resider	- AA	(Specify) SCENE
IVISION (Attending P Breath. Acror: After t	tification:	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	7-26 98		ork? □ Yes 200No	28d. Describe hov	et she	+
M	A Par	ELL.	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office		City or Town,	State)	or Rural Route Number,

29b. Signature and

31. Date filed (M

building, etc. (Specify)

1201 W. North AVE 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as stated.

It is of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

JULY 26, 1998

29a. Certifier (Check only

29d. Date signed (Month, Day, Year) 29c. License number

cause of death (Item 23e) (Type, Print)

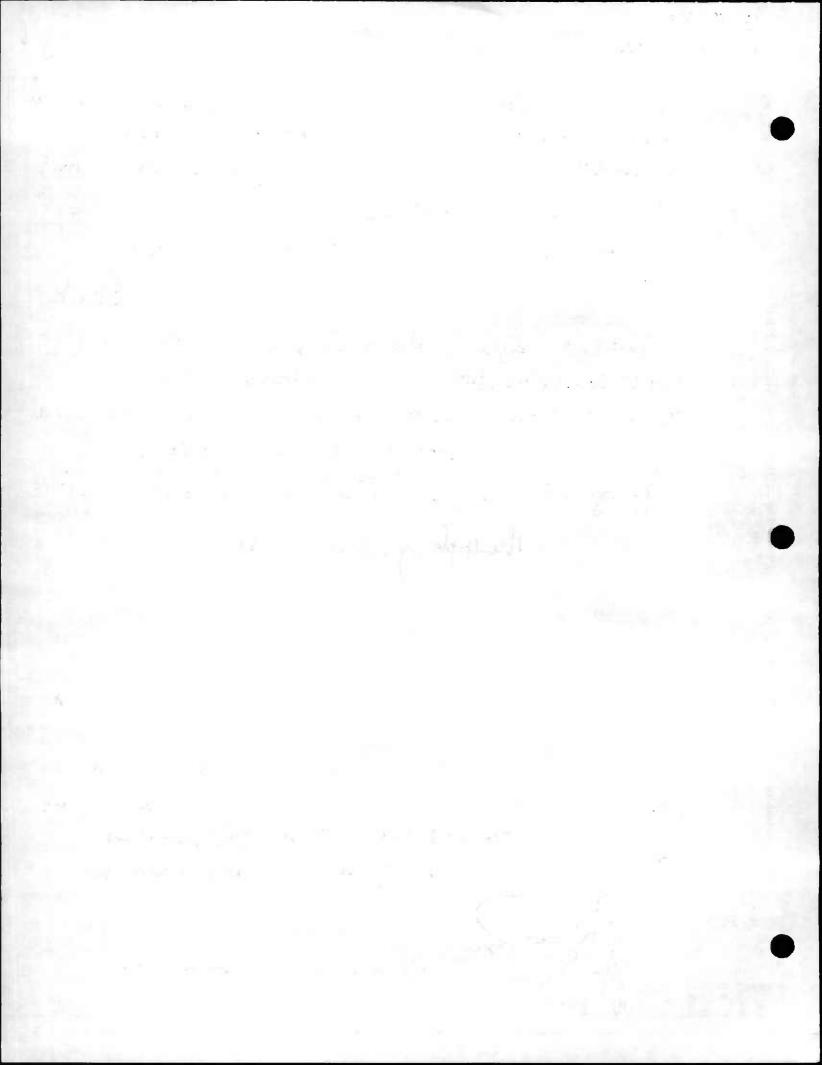
291998

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

Registrar

32. Registrer's Signature Dia Davidson-Randell



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	em: 20b per F.H. G- 1. Decedent's Name (First, Mid		eb	Cer	tificate of	Death	2. Date of De	Reg. No.	3 Time	of Deeth
Physician /Medical	WILLIAM JOHN		TICZ				Month JULY	Dey Y	/ear	O PM
Examiner	4a Facility Name (If not institu 130 EAST BA					4b. City, Town, or the BALTIMOR				
Funeral Director	5. Social Security Number 220–36–4157	6. Sex 1√2 M 2□ F	7. Age (In yrs.) 58	(lesf birthday) If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da April	th y, Year) 11 1940	9. Birthplace (State Country) 1940 Maryland	
show stat	Usual Residence of Decedent 10e. Stete 10b. Cour	nty	10c. City	y, Town or Lo	cation				10d. inside	City Lin
23a or 28a-f sho ust be notified at ral Director	Md. r	n/a	В	altimo	re				1 [XYe	es 2 🗆
or 28 Direction	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?	
re 23a	Md. n/a 10e. Street and Number 130 E. Barney Street 11. Marital Stetus 1 Never Married 2 Married 1 X Yes 2 No				Vas Decedent of H	21230	necify Yes or No	USA 14. Race	- American Indien,	
by by	1 Never Married 2 M 3 Widowed 4 XDivorce	Armed Fo	orces? 2 No ve	1	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 ☑ No Specify:				White, etc. White	
"natur deal	(Specify only hig Elementery/Secondary (0-12	dent's Education thest grade completed) College (1	1-4or 5+)	(Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Busi		Œ.
ther than	12 17. Father's Name (First, Midd	18. Mother's Na	me (First, Middle,	nsulator						
marked other than imatic event, tha M To Be Comp	William V. S	2-11-					a M. Har			
s mer aumet	19a. Informant's Neme/Relation	and Number or Ru	ural Route Numb	er, City or Town, S	tate, Zip Code)					
m 27 her tr	William Stank	ciewicz (S	ion)					ce, Md. 2		
Important: if item 27 is any injury or other trau	20a. Method of Disposition 1 Buriai 2 Crematio 4 Donation 6 Other		State Cle	emetery, crem	sition (Name of constory or other plane) n Memori	al Park	July 31 1998		ity or Town, State Park, Mo	d.
Important: any injury ange.	21. Signature of Funeral Servi	ce Licensee	Vast	22	McCull 130 E.	y-Polynia	ak Funer e. Balti	al Home More, Md	. 21230	
In and transit transit Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	a	Due to (o	Ae W	uence of):	ondie	el In	faces	20M	
physicies the burner and cal	resulting In death) Last	d		r as a conseq				15		
signed by the d be detached by Physi	d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ONLOW SCLOW'C HEART DISCARE 1 Yes 2 No 3 Probably									Unk
should should	Cov	ysm	re 17	Cen	+ 50	allu	24a. Was	an autopsy ormed?	24b. Were autops aveilable prio completion of of death?	or to
page 2	00	esitu	3.80				10	Yes 20 No	1 ☐ Yes 2	ZHO
rector, pag	25. Wes cese referred to med examiner?	Hospitai:			Ott		ath (Check only	one)		
After this funeral di	1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pen 2 Accident	28b. Time of Injury	28c. Inju	4 LI Nursing F	dome 5 Resi 28d. Describe	dence 6 Other				
Modified and Saled Ceeff. To the Funeral Director: Affect Completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Cou	id not be 28e. Place	of Injury - At ho ing, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or To	Streef end Number wn, State)	r or Rurel Roufe Nu	um <i>ber</i> ,
a ====================================	29e. Certifier 1 Certifier (Check only one) 1 Medic	ying Physician: To the al Examiner: On the band man	best of my know asis of examinat ner stated.	wledge, death tion and/or inv	occurred at the til restigation, in my o	me, date end piace opinion, deeth occu	e, end due to the urred at the time,	ceuse(s) end man date and place, an	ner as stated. nd due to the ceuse	e(s)
Per Fur		ifier			29c. Licens	se number	^	29d. Date signed	(Month, Day, Year))
To the Funeral Dir completaly filled in Medical Cert	29b. Signature and title of cert									
To the Furcompletaly completaly	29b. Signature and title of cert	L+ Ab	ous	Ju	vx 0	1272	7	7/28	198	

diagram vincins i . mw mg/ ve 10227-21 and the state of t

AMala jan ili graz grazifi turigi Mala manarat si u katika imanarati

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth July 1998 68 40 JAMES E. STENCIL, SR. 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth DEATON SPECIALTY CENTER BALTIMORE 6. Sex 1 ☑ M 2 ☐ F If Under 24 Hrs. 5. Social Security Number 8. Deta of Birth Month, Day, Year) OCt • 13 1953 7. Age (In yrs. lest birthday) Birthplece (Steta or Foreign Country) 44 Months Deys Hours Min. 216-62-5566 Maryland Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside Ctty Ltmits Md. n/a Baltimore 1 Ves 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1137 W. Cross Street 21230 USA 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merrted Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Ktnd of Bustness/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) City Government Municipal Employee 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumeme) Edward F. Stencil, Sr. Clara M. Cornwell 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James E. Stencil, Jr. Son 1137 W. Cross Street, Baltimore, Md. 21230 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition July 28 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovet from Stete Loudon Park Cemetery 1998 4 Donetion 5 Other (Specify) Baltimore, Md. 21. Signeture a perel Service Licensee 22. Name and Addrass of Facility
McCully-Polyniak Funeral Home 0 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Deeth Immediete Ceuse (Finel diseese or condition resulting tn death) 2 WKS al falluro Dua to (or es e consequance of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

physician and s the burial-transit

ettending for use es

signed by the e

After this certificate has

To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director,

þ

Completed

Be

2

Certification:

P.O.

Records.

Division of Vital

James

Stencil

Physician

/Medical

Examiner

10e Stete

Director

Funeral

Completed

Be

2

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Experient must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural, or ite any injury or other traumatic event, the Medical Examina.

Baltimore, Maryland 21215-0020

with the Marylend

death

Examiner Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Couse (Disease or injury that initiated evants resulting in deeth) Last Physician/Medical

Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert I.

1 ☐ Yes 2 ☑ No 1 Yes 2 2 No 26. Ptece of Deeth (Check only one)

25. Wes case refarred to medical 1 Yes 2 No 27. Menner of Deeth

Hospitet: 1 Øinpattant 2 □ ER/Outpatient 3 □ DOA 28e. Deta of Injury (Month, Dey Year) 28b. Tima of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how triury occurred

5 Pending Investigation 1 Neturet 2 Accident 3 Suicide 6 Coutd not be determined

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Straet and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and dua to tha cause(s) and menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steted.

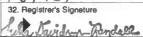
29b. Signature and title of certifier Chuchta, MD 29c. License number D34974 JULY

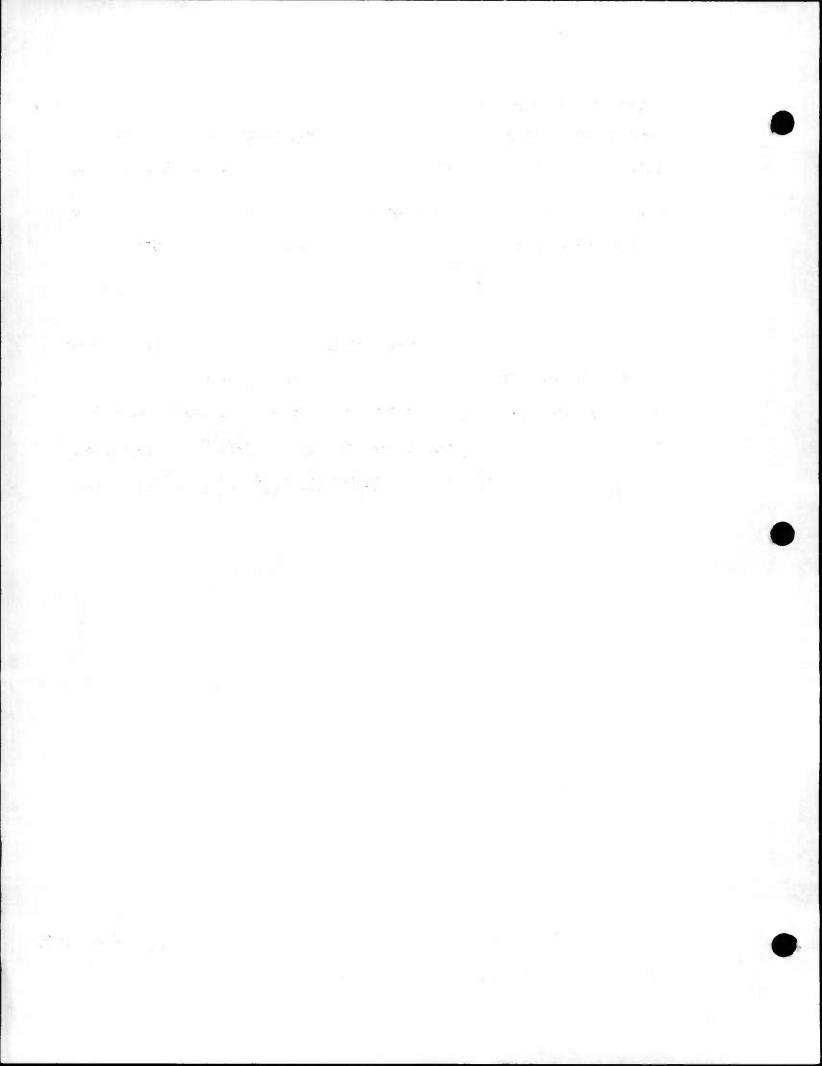
29d. Dete signed (Month, Dey, Year)

30. Neme end eddrass of person who completed cause of deeth (Itam 23a) (Type, Print)

CHARLE MEHTA, MD, 8975, Cloud leap ct, Columbia, MD21045

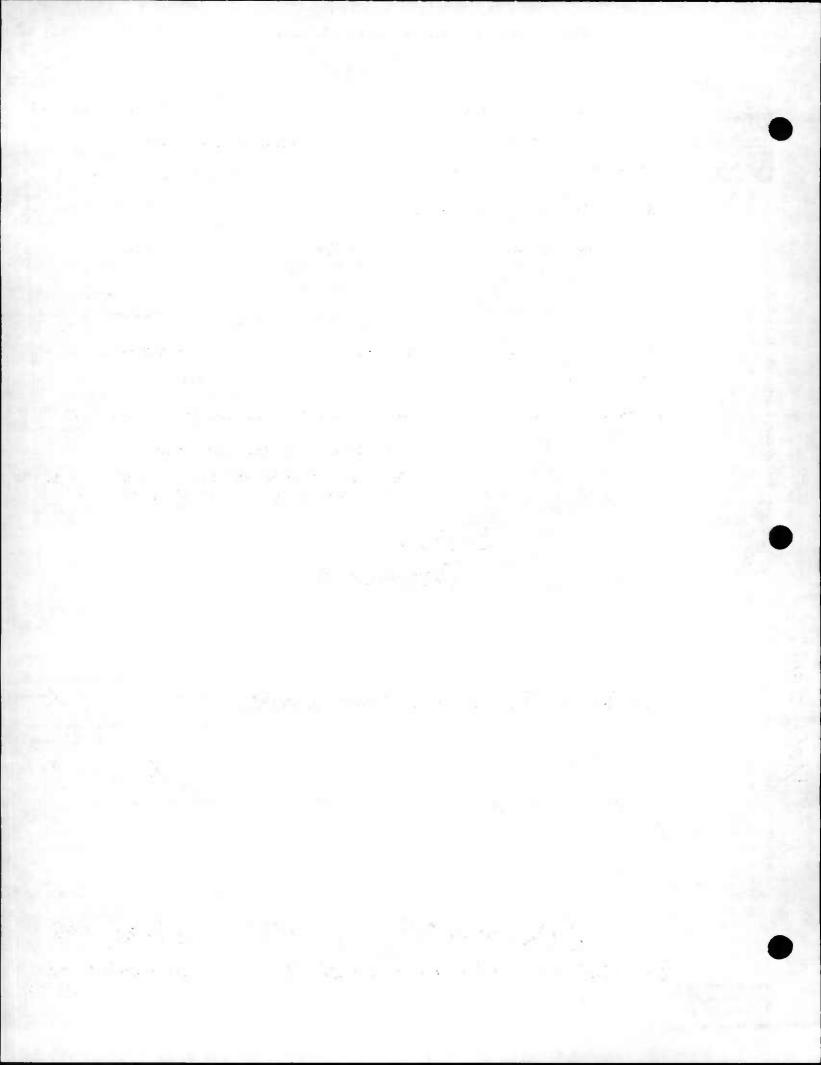
31. Dete filed (Month, Day, Year) State Registrar





State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Certificate of	Death	Re	ng. No.	3186						
	1. Decedent's Name (First, Middle, Last,				2. Dete of Deeth Month	Day Yeer	3. Time of Deeth						
Physician /Medical	Viola	D. Salvino			July	18 1998	7:49 PM						
Examiner	4a Fecility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death	4c. County of Deat	th						
	Bon Secours Hos		811.4.4	Baltimor	e City	N/A							
Funeral	5. Sociel Security Number 6. Sec	7. Age (In yrs. In 70	ast birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign buntry)						
Director	220-24-4210 Usual Residence of Decedent	χ / / υ			Apr. 14	, 1928 Ma	ryland						
show of all	10a. State 10b. County		r, Town or Location				10d. Inside City Limits						
Man Man	MD N/A	Ba	ltimore City				1)XIYes 2□No						
ith the M or 28a-f	10e. Street end Number		10f. Zip Code	7.	10	10g. Citizen of What Country?							
of effect death with the Ma or ferms 23s or 28s-fs order must be notified Funeral Director	503 South Pulaski	Street	2122	3		USA							
tems ar dea		12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Decedent of If Yas, specify Cu	Hispenic Orlgin? (Sp ban, Mexicen, Puerto	ecify Yes or No- Ricen, etc.)	14. Race - Ame Black, Whit							
ozo or selfe	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give	1□ Yas 2√ No	o Specify:		Specify:	White						
1215-0020 within 72 hours efter death with the Maryland and than "netural", or items 23s or 28s-f show the Medical Examiner must be notified at impleted by Funeral Director	15. Decedent's Edu	Year or Dates:	16e. Decedent's Usual Occi	upation		16b. Kind of Business							
I 21215-0 led within 72 ho tygiene. The Medical Completed	(Specify only highest grade Elamantary/Sacondary (0-12)		(Give kind of work don life. DO NOT use retir	e during most of work red)	ing								
d with displaying the response of the response	6	0	Waitress			Restaurant							
be filed that dother event, I Be Cc	17. Father's Name (First, Middle, Last)	Windberg		18. Mother's Nam	e (First, Middle, M	faiden Sumame)	THE PERSON NAMED IN						
should be and Mentel merked o	Frank Harrison			Sadie	Hullett								
Aar 2 sh and is m	19a. Informant's Name/Relationship (Ty			City or Town, State,									
	Pat Bowers/Daughte	20b. Pi		ore City,									
or o	20a. Method of Disposition 1 □ Burial 2 🖒 Cremation 3 □ F		20c. Location - City or										
Baltimore, semit. Pages 1 er Department of Hee mportant: If Nem any Injury or othe safe.	4 □ Donation 5 □ Other (Specify) Baltimore/Washington Crm. 7/24 Laurel, MD 1. Signeture of Funeral Service Licenses 22. Name end Address of Facility												
Baltimo pemit. Pege. Department of Important: If I any Injury or pnce.	21. Signeture of Funeral Service Licen	@ Meadowr	ridge Mem Pk										
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Physician /Medical	Immediate Cause (Final	SPA	()(
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Box (sath certif ettending for use e													
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Division of Vital Records, P or Attending Physician: The law requires that after death. Director: After this certificate hes been signed I in by the funeral director, page 2 should be detertification: To Be Completed by P					24a. Was er		Were autopsy findings						
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in: Tr. in in: Tr.	25. Was cese referred to medical			26. Place of Deal		- X	1 105 200 100						
Of Vita Physician: this certific ral director.	examiner?	lospital:	ER/Outpatient 3□ DOA	thar:		nce 6 □Other (Spe	ncify)						
On of Ming Physical distributions of the Tions of the Tio	27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In Injury		28d. Dascriba ho								
Vision Attending F r death. botor: After by the funer ification:	1 Natural 5 Pending 2 Accident invastigation	(World)		☐ Yes 2☐ No									
ivision in the control of the contro	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, offic	е	28f. Location (Str.	reet and Number or R n, State)	lural Route Number,						
Division c he Hospital or Attending P in 24 hours after death. The Funeral Director: After to pletely filled in by the funeral edical Certification:													
Hospital 24 hours 24 hours Funeral stely filled	(Check only 2 Medical Examin	ner: On the basis of examinati	wledga, death occurred at the ion end/or investigation, in my										
222c W	one) 29b. Signeture and title of certifier	and manner stated.	29c Line	nse number	20	9d. Date signed (Mon	th. Day, Year)						
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				21000	_	7017 62	(110						
	30. Name and address of person who co	mpieted causa of daath (Itam	RNF4 MV	700 4	JASH R	SIVO BA	LT AUD						
State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	.000	10		21230						
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				Cer	tificate of	Death			Reg. No.	0 4	3181
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5. Soc	4001 EDMONDS		7. Age (In yrs. la	ast birthday)	If Under 1 Yaar	If Under		8. Date of Bi	rth		ace (State or Fo
215	5- 90-0346 Residence of Decedent	1⊠M 2□F	20	Yrs.	Months Days	Hours	Min.	(Month, D)	ay, Year) - 78	Count	mD (m)
10a. S	State 10b. County		10c. City,	, Town or Loc	cation					10	d. Inside City Li
T	MD BALTI	MORE		٨	J/A						1 ☐ Yas 2 ☑
10e. S	Street and Number				10f. Zip Code				10g. Citizen of	f Whet Count	try?
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	Never Married 2 Marrie	d 1 ☐ Yas If Yes, Giv	2 No		Yes 2 No				Spec		
3 [□ Widowed 4 □ Divorced	Year or Da								DUAC	
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302	Method of Disposition	HUN III	OTHEK 200 PI	3104	sition (Name of	OKD,	PL.	Date Date	20c. Location	City or To	wn State
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23a.	Part1. Enter the disease, or c shock, or heart failure. List or	complications that co	aused the death.	51	AUGHN C 51 BALT	GRE 6. NA	ENE IL P	IKE,	BALTO.		21229 Approximata Interval Between
	shock, or heart failure. List or	complications that co	aused the death.	51 Do not ente	AUGHN C 51 BALT or the mode of dy	GRE 6. NA ing, such as	ENE TL P cardiac	IKE or respiratory	BALTO.		21229 Approximata Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
291998

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

24, 1998

JULY

30. Name and addrass of person who completed cause...

Joseph Pestaner

32. Regis

who completed cause of death (Item 23a) (Type, Print)

ESTANE 111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature

Alberta Control of the second

Letter Anna Barrer Barrer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month July 26 1998 4:20PM John Thomas Simms 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) Woodlawn Baltimore 1603 Langford Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Sept. 7 Birthplece (State or Foreign Country)

Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) Deys Hours Min 1 M 2 □ F Yrs. 69 Sept. 1928 217-22-0504 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Woodlawn 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number U.S.A. 21207 1603 Langford 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Baltimore City Policeman 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Katherine Kelly Lawrence Simms 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Rejetionship (Type, Print) 1603 Langford Rd Woodlawn, Maryland 21207 Gladys Simms/ Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/30/ 1⊠ Burial 2 ☐ Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 1998 Baltimore, MD 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Ave Catonsville, MD 21228 23a. Pert1. Enter the disease, of chimplications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) e acute myelogenous Reals Due to (or es e consequence of). Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were eutopsy findings avellebte prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

10e. Stete

Funeral

Director

death with the Maryland

Baltimore, Maryland 21215-0020

filed within 72 hours efter death with the Marylan Hygiens. Hygiens than "natural; or items 23a or 28a-1 show ent, the Madical Examines man be notified at

pemit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, the once.

Examiner Physician/Medical the th use as

sician and buriel-trans ettending for use as signed by the eld be detached for þ Completed peen After this certificete has funeral director, page 2 Be 2 Certification:

The law requires that the death certiticate be executed

Division of Vital Records, P.O. Box 68760 or Attanding Physician: death. efter deat Director: 2 To the Hospital or within 24 hours eft To the Funeral Dicompletely filled in

the

State Registrar

Medical

29b. Signeture end title of certifier

Beverl 31. Dete filed (Man

in, Day

Welleker

Pert ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 1 ☐ Yes 2 1 No 1 Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Aesidenca 6 ☐ Other (Specify) 1 Yes 24 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 5 Pending investigation 1 Naturel fnjury 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) end menner es steted.

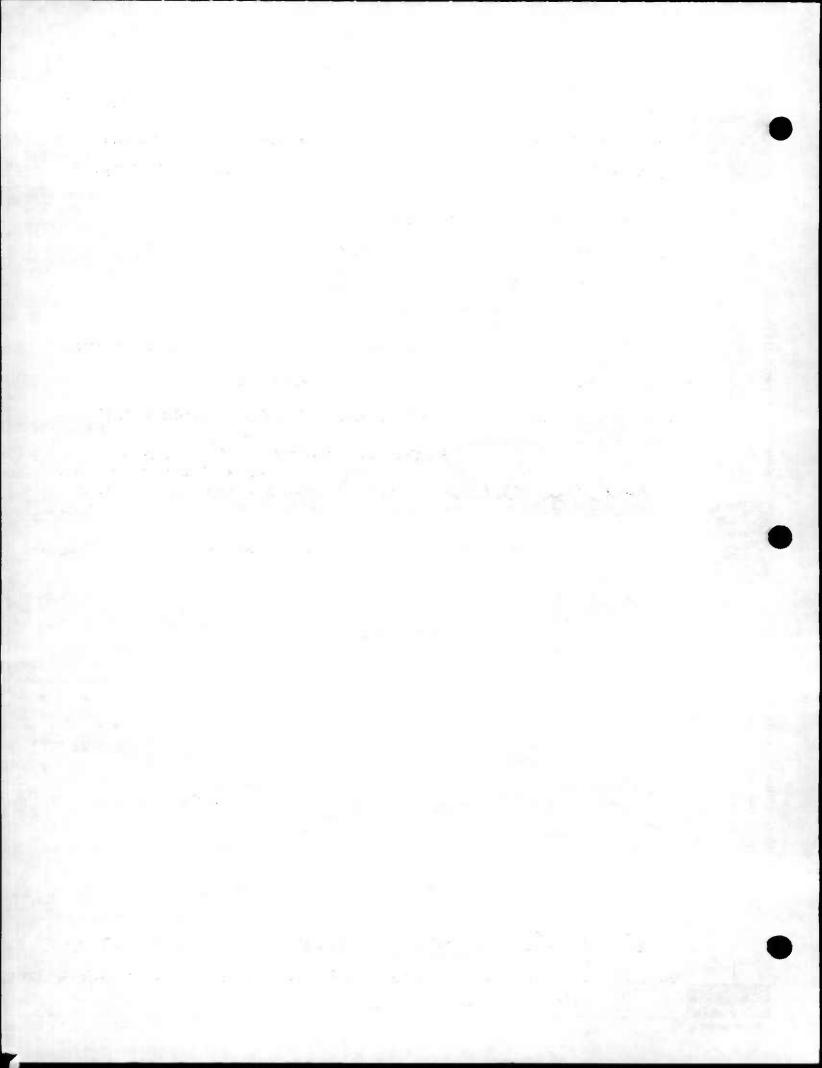
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifier

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 600 North Wolf Street Boltmore Mary bad 21287 32: Registrer's Signeture e Devidson-Agnober

52133

29c. License number

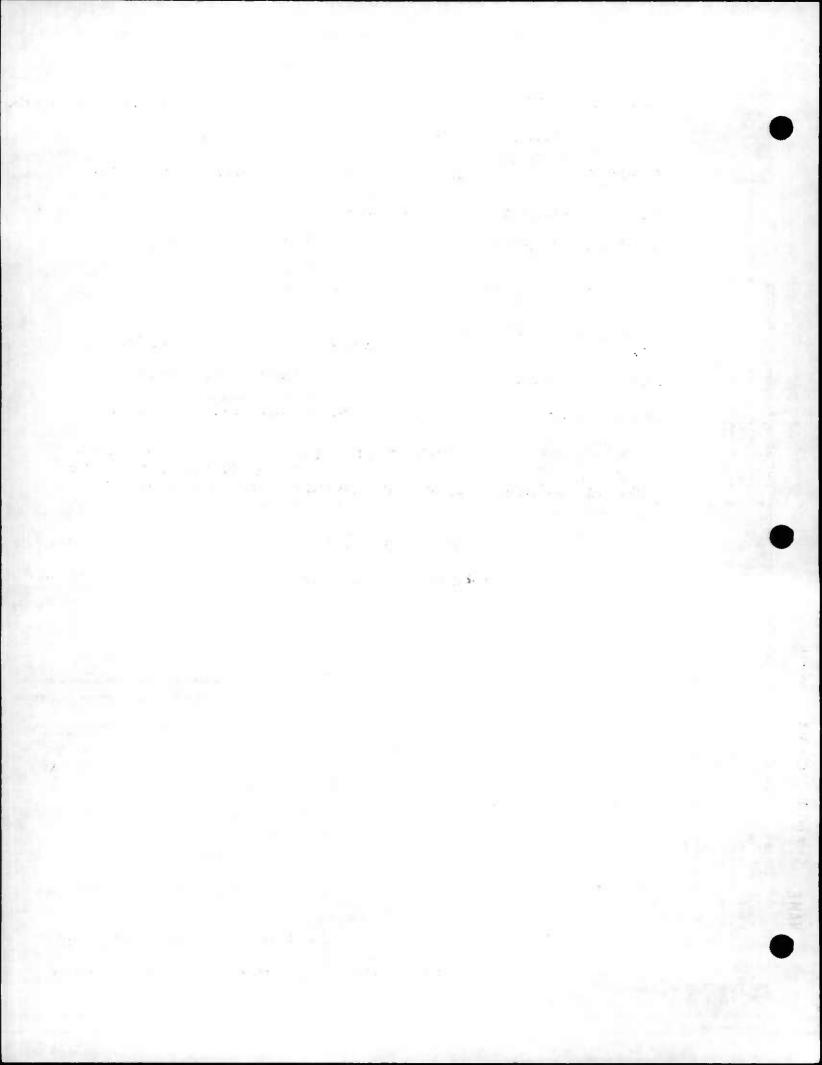
29d. Dete signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			C	ertifica	te of L	Death		Reg. No. 98	2	3189
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Examiner	4a Fecility Neme (If not institution, give				4	b. City, Town, or L		h 4c. County	of Deeth	
	ST AU	MES HEAL					imore			
Funeral Director	5. Social Security Number 6. Si 214-54-3945 Usuel Residence of Decedent	9x 7. Age (In yrs	s. lest birthda Yrs.	Months	Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De June 2		9. Birthp Coun MD	lecs (State or Foreign try)
lend lend	10e. State 10b. County 10c. City, Town or Location								1	0d. Inside City Limits
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y, Maryland 21215-0020 and 2 should be filed within 72 hours effer death with the Maryland salth and Mentel Hygiene. To le marked other than "neture!, or items 23e or 28s-f show her traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	U,S. 13	3. Was Dece If Yes, spe 1 Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No D Ricen, etc.)	Specify	e - Americ ck, White, :: whi	etc.
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O	20e. Method of Disposition 1 □ Burial 2 ☑Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Removal from State	Plece of Dis	remetory or	other plec	ton Crem	Date 7/29/	20c. Location - 98 Laur		
Baltimor Bartimor Permit. Pages Depertment of the Important: if its any injury or of once.	21. Signature of Funerel Service Licen			22. Name e	nd Addres	dson Ave	tzke Fu	neral Ho	mes,	Inc.
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Examiner	resulting in death)	Due to	(or es e cons	sequence of):		OF 121			
nine ed		b. CROW	h's	Di	seas	se				Years
760, be executed sician and buriel-trensit	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or es e cons	sequence of):				i	
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Box 6/ leath certific ettending p I for use es		d							1	
deat deat sicis	Pert II. Other significant conditions co	ontributing to death but not re	sulting In the	underlying	cause give	en In Pert I.	23b. Did	tobacco use co	ntribute to	o the cause of death?
, P.O. BO) thet the death or ed by the ettend deteched for us							1	Yes 2□ No	3 Pro	bably 4 Unknow
al Records, P.O. Box 68760, The law requires thet the death certificate be executed at hes been signed by the ettending physician and page 2 should be deteched for use as the buriel-trensit Completed by Physician/Medical Examilia						AT L		en eutopsy ormed?	ev	ere autopsy findings eileble prior to impletion of cause
I Rec The law ate hes page 2							40	Yes 2 No		deeth?
	25. Wes case referred to medical					00 81				Yes 2 No
f Vital ysician: Tracentificate director, pa	exeminer?	Hospitel: 1 Inpatient 2	☐ ER/Outpat	ient 3 D	Other	26. Place of Dee		one) Idence 6 🗆 Oth	or (Coopie	6.1
On of Value Physical direction: To	27. Menner of Death	28e. Date of Injury (Month, Dey Yeer)			28c. Injun Worl	- Hursing H		how injury occur		9/
Sion tendin ter: Aff the fur catio	1 Neturel 5 Pending 2 Accident investigation		,,	М		Yes 2 □ No				
Division of Vita Division of Vita Hospital or Attending Physician: 24 hours after deeth. 24 hours after deeth. 24 hours after deeth. 31 hours after deeth. 31 call Certification: To Be (3 SuicIde 6 Could not be 4 HomicIde determined	28e. Place of Injury - At building, etc. (Spec	home, farm,	street, fecto	ry, office		28f. Location City or To	(Street and Numl wn, State)	ber or Rure	el Route Number,
Division C Division C To the Hospital or Attending P within 24 hours after deeth completely filled in by the funera Medical Certification:		ysicfan: To the best of my kr ifner: On the basis of examir end menner stated.								
To the within 5 to the comple	29b. Signeture end title of certifier			29	c. License	number		29d. Date signe	d (Month,	Dey, Year)
	Mark 3	nd	FA.		P	11698		July	27,	1998
10	30. Name and address of person who o	completed cause of deeth (lite		Print)	2	Balti	more	, mo	7	1229
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	neture	2.00						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decadant's Nama (First, Middla, Last) 2. Data of Death Month Day Yaar **Physician** 841 Pm 9.98 /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Howard County General Hospital Columbia Howard 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sax 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign Country) **Funeral** Days 561-34-7045 1 M 20 F Yrs. Director July 14, 1912 Pennsylvania Usual Rasidance of Dacedant the Merylend 10a, Stata 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mentei Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Madical Examiner mast to notified at any injury or other traumatic event, the Madical Examiner mast to notified at any bines. 10d. Insida City Limits Maryland | 1 ☐ Yas 2 ☑ No Director Howard Columbia 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5615 Columbia Road #102 21044 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva 11. Marital Status Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - Amaricen Indian, Black, Whita, atc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: white Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 5+ School Administrator Education 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Be John Dunn Florence Dougherty 10 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Thomas O. Schneider - son 5615 Columbia Road #102, Columbia, Maryland 21044 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Mountain View Cemetery 7/25/98 W. Hazelton, PA 21. Signatura of Funarai Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac prespiratory arrest, Dia not proximate. List only one cause on each line. Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Finai In faction disaasa or condition rasulting in daath) Examiner Examiner ettending physician and I for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Entar Undarfying Cause (Diseasa or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequance of): ate has been signed by the page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, à 24b. Ware autopsy findings availabla prior to complation of ceusa of death? Completed 24a. Was an autopsy performed? After this certificate hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician:
24 hours effer death.
 Funeral Director: After this certificaletely filled in by the funeral director, it Be 25. Was case rafarred to medice 26. Piaca of Death (Check only ona) examinar? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Yas 2 No 27. Manner of Death Certification: 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homiclde 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha causa(s) and manner as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a, Cartifiar To the Hosp within 24 hou To the Funer completely fil Medical 29b. Signatura and titia of certifi-29c. License number 29d. Data signed (Month, Day, Year)

Calumbia Mel 21044

State Registrar 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

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32, Registrar's Signature

Fulia Savidson

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 2:1291 98 25 uli 4b. City, Town, or Location of Death /Medical 4c. County of Death 4a F acility Name (If not institution, give street and number) **Examiner** Ba Ito N/A HOPKINS Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months 1√2 M 2□ F 215-18-7671 73 Vrs DEC 15, 1924 MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita If item 27 is marked other than "naturel", or items 23s or 25s-4 show or other traumatic event, the Maximal Examinar must be notified at TXTes 2 □ No N/A BALTO Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1832 E. MADISON ST 21205 U.S.A. parmit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) 7th CONSTRUCTION WORKER N/A CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ELMER TYLER MARIE STANLEY 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHARON TYLER/ WIFE 1832 E. MADISON ST BALTO, MD 21205 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) ARBUTUS MEM PK 7-30-98 BALTO, MD 22. Nama and Address of FacilityBETTS FUNERALHOME 21. Signature of Fer al Sarvica Licensa 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Between Onset and Death **Physician** myocardial interction Immediate Cause (Final disease or condition resulting in death) /Medical Immediate Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and P.O. Box 68760, The law requires that the death certificate be Dua to (or as a consaquance of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown obstructive Chronic pulmonory Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy s ueeq i certificate hes b 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 D Homicide within 24 hours af To the Funeral DI completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Breok, Rodney 0 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

Baltimore,

DHMH 16 Rev 6/95

State

Registrar

3411

31. Date filed (Month, Day, Year)

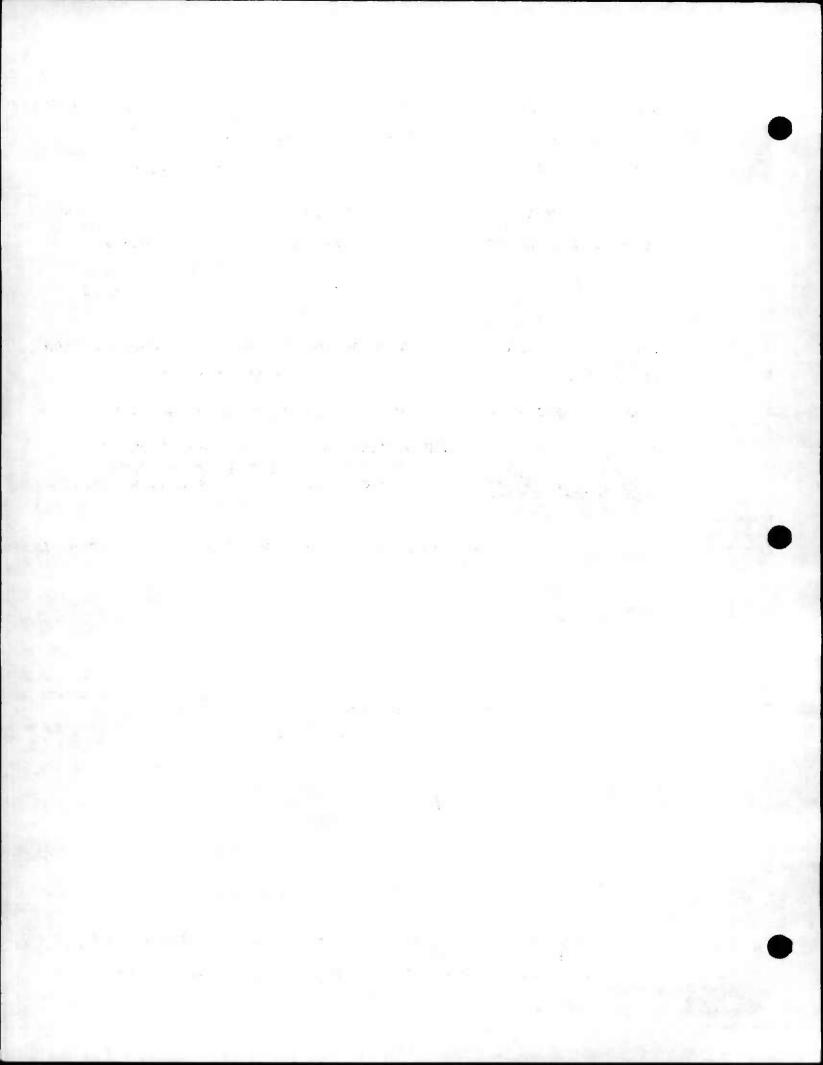
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State of Maryland / Department of Health and Mental Hygiene |

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Daeth 3. Time of Death Month **Physician** 5 a.m. July 26,1998 Mabel M. Varette /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) **Examiner** Future Care Chesapeake Arnold Anne Arundel Hours Min. 8. Date of Birth (Month, Dey, Yeer) May 17,1904 If Under 1 Year Birthpiece (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 1 M 2 F 94 Yrs 214-01-6139 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Pasadena Maryland Anne Arundel Directo 10g, Citizen of Whet Country? 10e. Street and Number 7806 Outing Ave. 21122 U.S.A. Funeral 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. White 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No "naturel", or Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) Homemaker Own Home peimit. Pages 1 and 2 should be file Department of Heatin and Mental Hy Important: If tem 27 is marked oths any injury or other traumetto event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be (Unknown) Baldwin Mary Elizabeth Bell P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 195 Magothy Beach Road Pasadena, Maryland 21122 Mary Kronsteiner Daughter Baltimore. 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 28 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park July 28,1998 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama end Address of Fecility 21. Signature of Funeral Service Licer McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 23a Fert1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feiture. List only one cause or each line. Approximata intervel Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examine Examiner ician and buriai-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Dys to (or as a conseque certificate be execu P.O. Box 68760 physician Physician/Medical the Due to (or as a consequenca of) use as jo Pert ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contributa to the causa of death? signed by the 20 No 3 Probably 4 Unknown 1 Yes Records, à 2 24b. Were eutopsy findings eveilable prior to complation of cause of deeth? Completed 24e. Wes en eutopsy certificate has 20 No 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital al of Attending Physician: The state death.

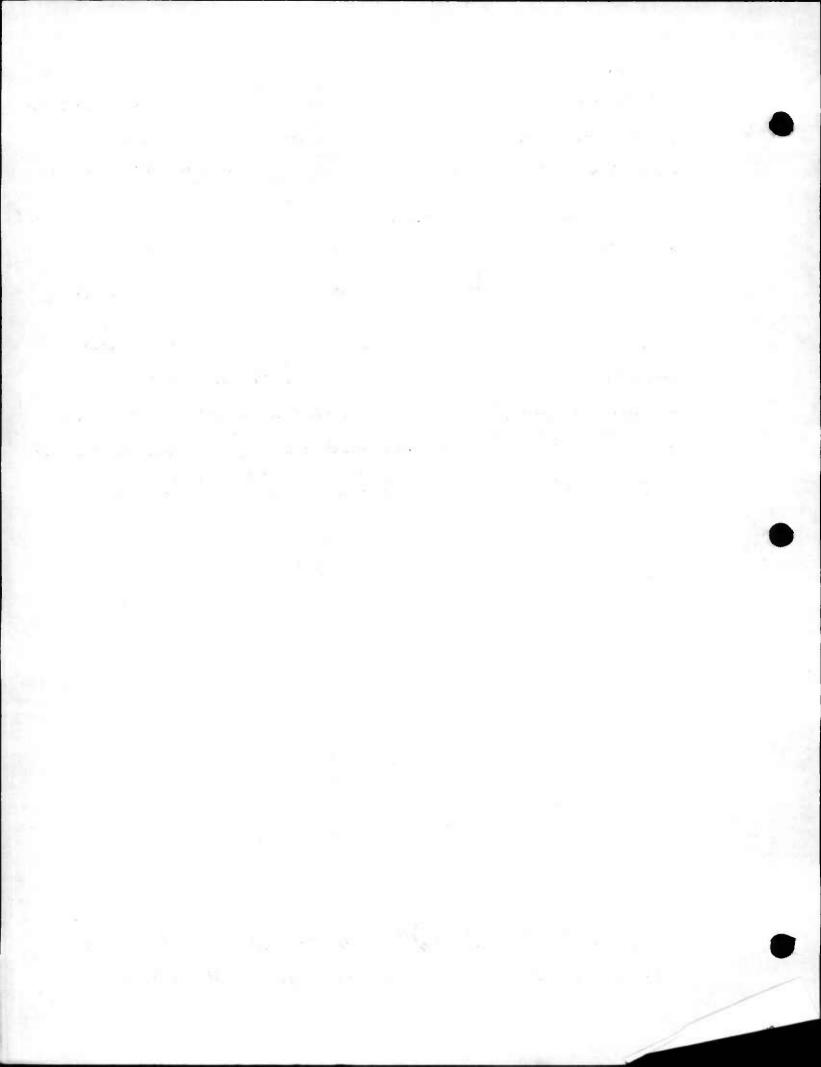
In Director: After this certificated in by the funeral director, pa 25. Wes case referred to medical examinar? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deetl 28e. Date of injury (Month, Dey Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide 24-hours a Hospital to Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as steted.

2 Medical Examinar: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. edical 29a, Certifier (Check only one) To the I within 2 To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of-certifier Attending Doctor 30. Nema and eddress of parson who completed ceuse of death (tem 23e) (Type, Print) RITCHIE UNI PASADENA, MD 21122 CN. CYRIAC-M-D 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

LUC CO		Decedent's Nema (First, Mic	die, Last)		7		Pertifica	01	Douin	2. Deta of Da		Vac-	3. Time of Deeth
Physicia /Medica		Donald G. W									17, Dey 199	Year 8	10:30 pm
Examine	er	4a. Facility Name (If not institute 9321 Kenbrook			ber)				4b. City, Town, or Laurel	Location of Deet	h 4c. County o		
Funeral Director		5. Sociel Security Number 219-68-7456	6. Sex		. Aga (In yrs	. last birthd	Month	lar 1 Yeer s Days		8. Dete of Bir (Month, De March	th 25, 1955		plece (Stete or Foreigntry) rginia
show		Usuel Residence of Dacedent 10a. State 10b. Coun	ty		10c. C	ity, Town o	r Location						
28a-f sh	ctor	Md. Ho	ward			Lauı	rel				10d. Inside		
or 28	Dire	10a. Street and Number 9321 Kenbrook					10f. 2	ip Code			10g. Citizen of W	het Cou	ntry?
11. Meritel Stetus 12. We Am 1 Never Merried 2 Merried 1				12. Wes Deced	20723 as Decedent Evar In U.S. ned Forces? 13. Wes Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, Flags and Specify: 1 □ Yes 2 □ Yes Specify:				lispanic Origin? (S an, Mexican, Puar	Specify Yas or No to Rican, etc.)	USA 14. Rece Bleck Specify:	c, White,	can Indien, etc.
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and Mental Is marked of	-	19e. tnforment's Neme/Reletio	ship (Ty)	oe, Print)		19b. M	elling Addre	ss (Straat			er, City or Town, S	Stete, Zip	Code)
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Department important: hany injury o	They > A							ss of Fecility Funeral ct Avenue		.A. l, Maryl	and	20707	
nysician		23e. Pert1. Enter the disease, shock, or heart failure. Li	or complic st only on	cetions thet cau e cause on eac	ised the dee sh lina.	th. Do not	entar tha m	oda of dyir	ng, such as cardia	or respiretory e	rrest,		Approximata Intervel Between Onset end Deeth
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28 2	Completed				9					24e. Wes	en eutopsy ormed?	CO	ere eutopsy finding alleble prior to mplation of causa death?
page page	50									10	Yes 2 No	1.	☐ Yes 2☐ No
certificate	e e	25. Wes case referred to medic exeminer?		nsnitel·				Oth		eth (Check only			
al di	Hospitel: 1 Inpatient 2 ER/Outpatlent 3 Society					28c. Injur Wor	4 LI Nursing F		dence 6 Othe how Injury occurre		ý)		
i Director						ory, offica				si Route Number,			
within 24 hours efter death. To the Funeral Director: After completely filled in by the funer Madical Cartifications.	29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time.						, end due to the rred et the time,	cause(s) and man dete end pleca, e	ner es s nd due t	teted. o tha cause(s)			
To	Σ	29b. Signature end title of certifier 29c. License number						29d. Date signed	(Month,	Dey, Yeer)			
0		30. Name and address of person	who cor	npleted cause	of deeth (Ite	1	pe, Print)	11	MANU	mm	20701	0	18
State Registrar		31. Dete filed (Month, Day, Yea	000	32. Reg	istrar's Sign		.00			010111	10		-

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Physician

Director

Funeral

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Examiner

Physician/Medical

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Certification:

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State of Maryland / Department of Health and Mental Hygiene

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WHITE ITEMS: #23 PART I, 27 PER MEO G761 7-31-98 WR. Certificate of Death

	Reg. No.		
2. Date of De	ath		3. Time of Deeth
Month	Day	Year	
JULY	26,	1998	1:20P.M.

4c. County of Deeth

 /Medical Examiner **Funeral** Director the Maryland worde. in than "natural", or items 23a or 28a-f ahov The Medical Examinet must be notified at

with 1

death

permit. Pages 1 and 2 should be filed within 72 hours efter bepartment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or free any Injury or other traumatic event

Physician /Medical

Examiner

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attanding physician for use as the burie

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Hospital or Attandi 24 hours after death Funeral Director: A

24 hours e Funerel [

To the Within 2 To the

certificate be exec Box 68760.

P.O.

Division of Vital

buriel-tran

the

Maryland 21215-0020

Baltimore.

4a Facility Neme (If not institution, give street end number) 3406 SOLLERS POINT ROAD 5. Sociel Security Number 6. Sex to M 2□F 216-34-4489

Richard Joseph White

1. Decedent's Name (First, Middle, Last)

7. Age (In yrs. lest birthday) 61 Yrs

DUNDALK If Under 1 Yeer If Under 24 Hrs. Hours

Specify:

4b. City, Town, or Location of Death

BALTIMORE

 Birthplace (State or Foreign Country) May 9,1937 Pennsylvania

10d. Inside City Limits

1 ☐ Yes 2/☐ No

10a, State 10b. County Md. Baltimore

Usual Residence of Decedent

Dundalk

10c. City, Town or Location

10f. Zip Code 10g. Citizen of Whet Country?

10e. Street and Number

3406 Sollers Point Road 12. Wes Decedent Ever in U,S. Armed Forces?

21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

Months

14. Race - American Indian. Black, White, etc.

USA

1 XNever Married 2 ☐ Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

1 ☐ Yes 2 X No If Yes, Give Year or Dates:

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify: White 16b. Kind of Business/Industry

Elementery/Secondary (0-12) 12 yrs.

School Teacher

1 ☐ Yes 2 No

Baltimore City

17. Fether's Name (First, Middle, Last)

Willam Thomas Kunaitis

Agnes Elizabeth Kunaitis

18. Mother's Name (First, Middle, Maiden Surneme)

19e. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 3004 Baybriar Road Balto. Md. 21222

Patricia A. Byer sister 20a. Method of Disposition 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State

20b. Place of Disposition (Neme of cemetery, cremetory or other place) Metro Crematory

20c. Location - City or Town, State July,

4 ☐ Donation 5 ☐ Other (Specify)

30,1998Catonsville, MD 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A.

7110 Sollers Point Road 21222

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart takens. Let only one cause on each line.

Immediate Ceuse (Final diseese or condition resulting In death)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Interval Between Onset and Death

Approximate

Due to (or es e consequence of) Due to (or es a consequence of)

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequence of)

Injury

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of ceuse of deeth?

2 No

Yes

25. Was cese referred to medical Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA

26. Piece of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

2 No

27. Menner of Death 1 X Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Yes

29a, Certifie

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signat nd title of centifi 29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year)

JULY 27, 1998

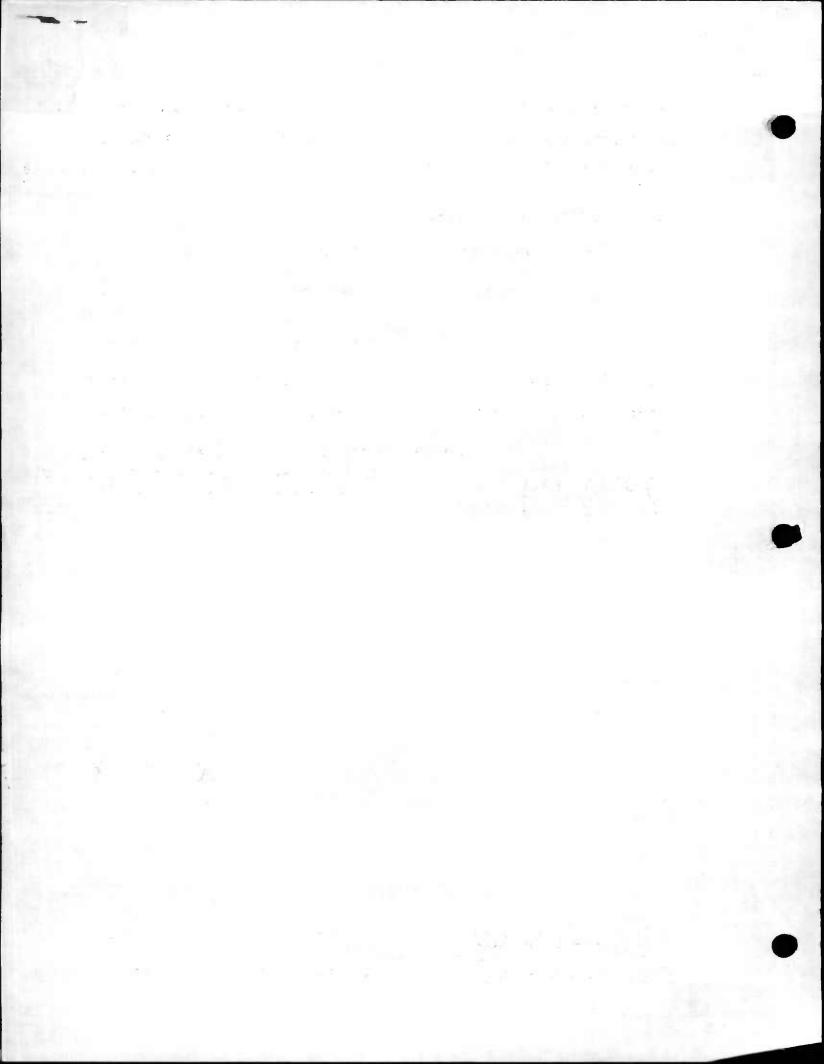
of death (Item 23e) (Type, Print)

30. N ess of persor wick Me

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 29199 JUL

32. Registrar's Signature invarian



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	Death		Reg. No.	23195	
Physician		lame (First, Middle	Last)	V	7/17	Eq. 1		2. Dete of De Month	Dev	3. Time of Deet	
/Medical	1,1119	dred		Young	*			July To	venty Seven	North 2:45 PM	
Examiner	4e. Fecility Neme (If not institution, give street end number) Good Samaritas Harital							or Location of Deat			
	G000	1 Jamarite				If I looker 4 Vee		e, Marylan		smore City	
Funeral Director	5. Sociel Securi 213-10		6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last 88	Yrs.	Months Dey		lin. (Month, De	19, Yeer) 2, 1909	9. Birthplece (Stete or Fore Country) Maryland	
and *	Usuei Residenc	a of Decedent		10c. City, T	own or Loc	eation				10d. Inside City Lin	
the Marylar 28a-f show colling at	Marylar		imore			County				1 ☐ Yes 2 🛣	
the the	2711 Berwick Road				IMOLC	10f. Zip Code		10g. Citizen of V	What Country?		
ath with						21234			U.S.A.		
within 72 hours after death with the Maryland ene. Then "natural", or items 23s or 28s-f show the Mexical Examination must be notified at more properties of the properties of	3 St Widowe	us Nerried 2□ Marrie ed 4□ Divorced	Armed For	ces? 2.⊈No		Vas Decedent of Yes, specify Cu		(Specify Yes or No Jerto Rican, etc.)	Specify	e - American Indien, ck, White, etc. :: White	
ygiene. Ner than "natural it, it = Mexical Completed	(S	15. Decadent's	s Education	1	6e. Deced	ent's Usuel Occ	upation e during most of	workina	16b. Kind of Bu	usiness/Industry	
iene. then "	Elementary/S	econdary (0-12)	College (1	4or 5+)			e during most of (ed)	g			
at Hygiene of other than event, tre N						Homemak	7			Home	
To Be Comp	W1111	me (First, Middle, L Lam J. Bi						lame (First, Middle, Maiden Sumame) Brunner			
1 m m	19a. Informent's	s Neme/Rejetionsh A. Peder	ip <i>(Type, Print)</i> :sen -daug					Rural Route Numb e,Baltimo		State, Zip Code)	
anto nt if	20a. Method of l 1 ☐ Buriei 4 ☑ Donetic	City or Town, Stete									
Department important any injury once	4 to Donellon 5 □ Other (Specify) 21 Signature of Fuderel Servica Licenses Wade Director State Anatomy Board, 655 W. Baltimor										
og the second	1 60	Ronal	d Sy Wade	ard, 655	W. Balti	more Street					
	230 Petit For	10000	1 al	Unand the death. I				and 21201		Annualmaka	
	shock, or i	neart feilure. List o	complications thet ca only one ceuse on es	ech line.	o not ente	i the mode of d	Ally, such as care	diac or respiretory e	rrest,	Approximate Intervei Between Onset end Deeth	
nysician Medical	Immediate Ceu	se (Finel	Ac	to V	hus	carde	el K	stacet	100	32-5	
xaminer	disease or condition resulting in deeth) e.						0(00		300 /3		
- i				Due to (or es	e consequ	Jence of):					
n and ial-transit Examiner			b	5						i	
ing physician and a as the burial-transit	Sequentially list if eny, leeding to cause. Enter U Ceuse (Disease	conditions, o immediete		Due to (or es	e consequ	ienca ot):					
sicia e bur		Due to (or on a consequence of)									
ing physicia a as the bu	resulting in deal	esulting In death) Lest Due to (or as e consequence or):									
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d for us	Port T Other els	mificent condition	e contributing to do	ath but not regultin	a in the un	darluing cause of	in an in Bod I	23h Did	tohama umana	ntribute to the cause of do	
ed by the attend detached for us	Pert IT. Sther elgnificent conditions contributing to death but not resulting					derlying cause g	iven in Pert I.		23b. Did tobacco use contribute to the cause of c		
<u>5</u> 2									en eutopsy	24b. Were eutopsy finding	
page 2 should								perio	ormed?	eveilable prior to completion of cause of deeth?	
page 2								10	Yes 20 No	1 ☐ Yes 2 ☐ No	
certificate rector, pa		eferred to medical					00 01			TILL TOS ZILL NO	
	examiner	No No	Hospitel	nationt 2 ED	Outpetient	3[] DOA C	ther	Deeth <i>(Check only o</i> a Home 5 ☐ Resi		or (Spenity)	
6 5	imparient 2 Ervourpetient 3 DOA 4 Nur								how injury occurr	1.7	
Affer Affer	Naturei 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No										
s after death. In Director: After this ed in by the funeral d Certification: Te	27 Mamper of Deeth Stature Statu					1	28f. Location (Street end Number or Rurel Route Number City or Town, State)				
within 24 hours after de To the Funeral Directo completaly filled in by th Medical Certific	29a. Certifier (Check only (Check only and other) 29a. Certifying Physician: To the best of my knowledge, death occurred et the time, details of examination end/or investigation, in my opinion,				time, dete end ple	ece, end due to the	ceuse(s) end me	anner es steted.			
the F		0	end menn	er steted.	0110/01/11/1			oddred of the time,		5110 000 10 110 00030(3)	
To the com	296. Signafish a	Tube of Cedifier	bred	(L	0	D16	nse number		29d. Date signed	d (Month, Dey, Year)	
	30. Name end e	ddress of person w	ho completed cause	of death (Item 23	e) (Type, P	Print) s	0		0	. (0	
	DAVIG) Go	LP SCOME	3/2 5	601	Lo	ed 14	aven	DUD)	
State		fonth, Day, Yeer)	32. R	gistrer's Signeture	מ	1.00					

A. D.

		kc		iai yiai				f Death	d Mental H	Reg. No	er 10 1	23196
icia		Decedent's Name (First, Middle, I	Lest)						2. Date of D	Death De	y Year	3. Time of Deeth
ica	al .	Hobert Leste							July	11	1998	3:25 PM
e	er	4a. Facility Name (If not institution, g							or Locetion of Dea		County of Dea	ath
	-	VA Maryland Heal 5. Social Security Number 6			last birthd	foul If Und	er 1 Yea		Point		ecil	
		246-22-0333 Usual Residence of Decedent	100 M 2□ F	74	Yrs	Month			frs. 8. Date of Blin. Jan	30, T	924 Wes	rthplace (Stete or Foreigountry) st Virginia
		10a. State 10b. County		10c. Cit	ty, Town o	r Location						10d. Inside City Limit
1	Director	MD Harf	ord	Pe	errym	an						1 ☐ Yes 2K☐ N
-		10e. Street and Number				10f. Z	ip Code			10g. Cit	tizen of What C	ountry?
	<u>a</u>	423 Pollack Dr			21130						U.S.A.	
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	?	l,S. 1	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1□ Yes 2₺ No Specify: Specify: Specify: Whi					te, etc.	
Completed t		15. Decedent's			16a. De	ecedent's Us	ual Occi	upation		16b. K	ind of Business	/Industry
	Die	(Specify only highest s Elementary/Secondary (0-12)	rede completed) College (1-4or	E.1	(G	ive kind of v e. DO NOT	vork don use retir	e during most of red)	working			, made try
-	O	6	0	3+/	Lal	borer	Concrete 11					Finisher
		17. Father's Name (First, Middle, La	*		18. Mother's Name (First, Middle, Maiden Sumeme)							
F	0 26	John Lester Ba	re		Sara Jane Bare							
	- 1	19a. Informant's Name/Relationship			19b. M	lailing Addre	ss (Stree	et end Number or	Rural Route Num	ber, City o	or Town, State,	Zip Code)
	-	Ruth Jackson (Si	ster-in-la		19	75 Pop	lar	Ridge R	d., Pasa	dena,	Maryla	and 21122
	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from State			sposition (N cremetory or			Date 7		ocation - City or	
		4 □ Donation 5 □ Other (Spec		Spe	sutia	a Ceme	_	•	1			Maryland
		21. Signature of Funeral Service Lic	ensee			Tarri	nd Add	ress of Facility Cargo Fu	neral Ho	me. F	P.A.	
L		Lenneth	D. 694	40		Aberd	leén,	Maryla	nd 2100	1-339	9	
	1	23a. Fart1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one ceuse on each	the deat	h. Do not	enter the me	ode of dy	ring, such as cere	diac or respiretory	arrest,		Approximate Interval Between
	4	Immediate Cours /Final										Onset and Deeth
		Immediate Cause (Final disease or condition resulting in death)	Myocardial Infarction									4 Days
-	_ a		Due to (or as a consequence of):									1
and and	кашпе		b. Coror		_	y Dis						Years
	Exa	Sequentially list conditions, if any, leading to immediate	Due to (or as e consequence of):									i
		cause. Enter Underlying Cause (Disease or injury thet initiated events	c	Dun to /o								1
100	B	resulting in death) Last		Due to (o	ras a cons	sequence of):					1
100	2		d									
SINIS	rnysician/medical	Part II. Other significant conditions	contributing to death t	out not resi	ulting In the	e underlying	ceuse o	iven in Pert I.	23b. Die	d tobecco	use contribut	e to the cause of dea
240	r n				1,5		2 5					robably 4 🔀 Unkno
3	2											
Platon	Completed								24a. Wa	s en autor formed?	psy 24b.	Were autopsy finding available prior to completion of cause of death?
1	LO								10	Yes 2	& No	1 ☐ Yes 2 ☐ No
		25. Was cese referred to medicel						26. Place of I	Death (Check only	one)		
	2	examiner? 1 Yes 2 No	Hospitai:	ent 2	ER/Outpa	itient 3 🗆 🛭	OOA	thor	g Home 5□ Res		6 □Other (Spe	ecify)
		27. Menner of Death 1 ☑Natural 5 ☐ Pending	28e. Date of Inju (Month, De	y Year)	28b. Time Injur		28c. Inju		28d. Describe			
Cartification	3	2 ☐ Accident investigati										

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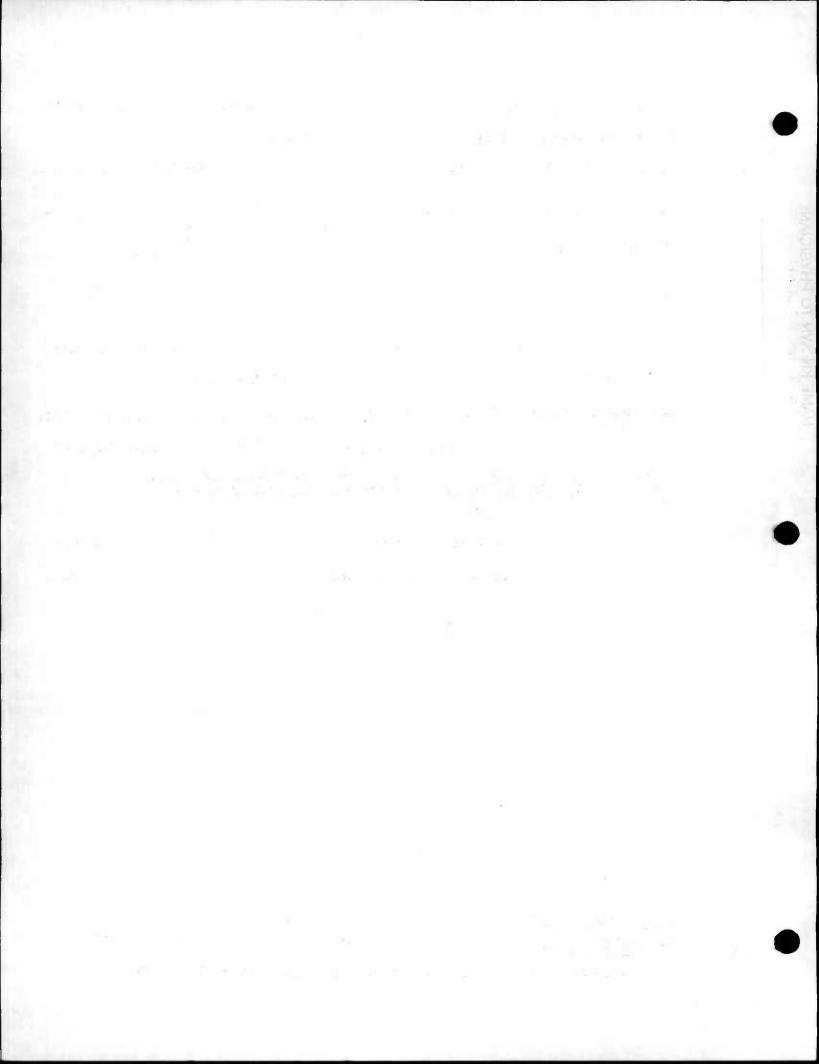
THOMAS FINUCAN, M.D., VA Maryland Health Care System, Perry Point, MD
31. Date filed (Month, Devry 2013) 98

of person who completed ceuse of death (Item 23a) (Type, Print)

July 11, 1998

201

State Registrar

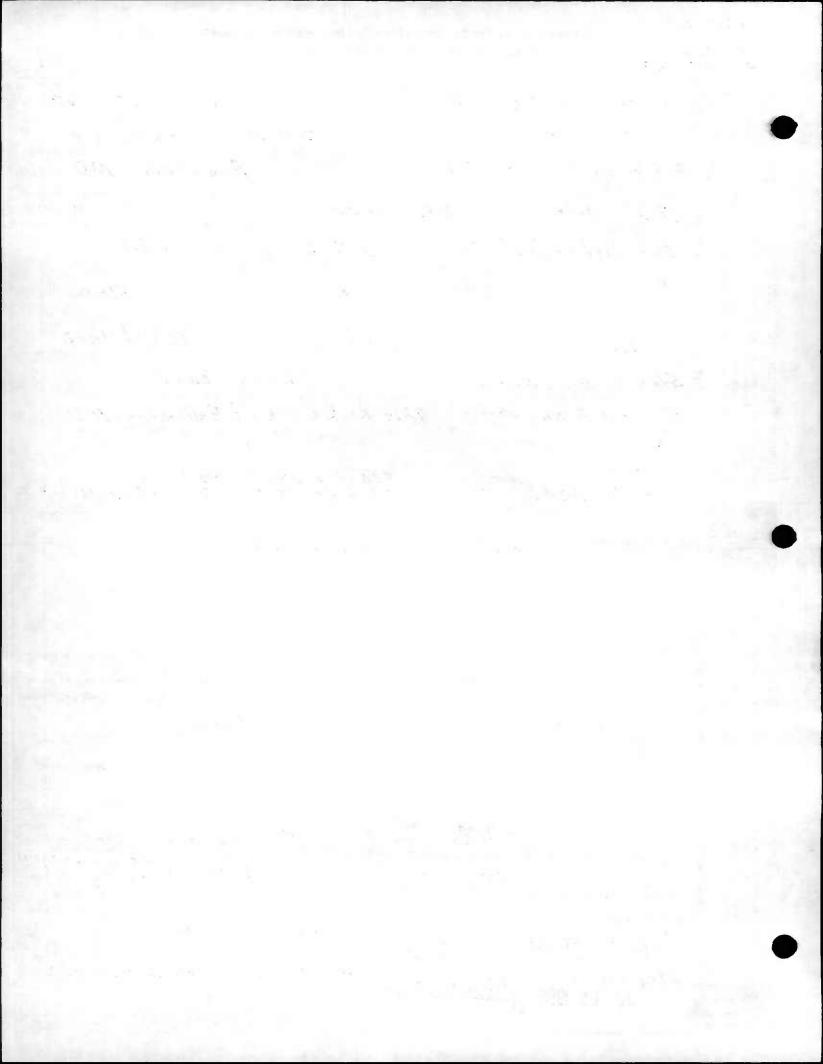


UNK	98-146	5
asp	KELLV	BIN

State of Maryland / Department of Health and Mental Hygiene Q

	asp KEL	LY BUNN	otato of marylani	Certificate of	of Death		Reg. No.	23191	
	Physician /Medical	1. Decedent's Neme (First, Middle, L KELLV M	ast) ARIC BU	UNN		2. Dete of Dec Month JULY		3. Time of Deeth 98 2339	P
	Examiner	4a Facility Nama (If not institution, give street end number)				ity, Town, or Location of Deeth 4c. County of Deeth			
re, Maryland 2121	Funeral Director	730 LENNOX ST. BALTIMORE 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthday) 1 Yrs. BALTIMORE BALTIMORE BALTO, CITY 9. Birthplace (State or Foreign Country) Months Deys Hours Min. HUG. 29, 1976 MD							
	Maryland f show	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD C, '+x BALTIMORE 12 Yes 2□No							
	ter death with the Maryler terms 23a or 28a-f show the must be notified at "uner al Director"	100. Streel end Number 10f. Zip Co 2/2					10g. Citizen of Whet Country?		
	urs af	11. Meritel Stetus 1 Never Married 2 Married	Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, specify 1 ☐ Yes, Give 1 ☐ Yes, Give			pecify Yes or No to Rican, etc.)	14. Raca - American Indien, Bleck, White, etc. Specify: Black		
	c 1 4 3	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)			ccupation one during most of wo stired)	ation fluring most of working 16b. Kind of Business/Industry Child Care			
	d out	17. Fether's Name (First, Middle, Last) Steven ARizmendi				i. Mother's Name (First, Middle, Maiden Sumeme) Sharok BUNK			
	Haalth ar Haalth ar tam 27 is other trau	19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip C 5 harox Bunn — Mother 7214 Rock Ridge Rd Baffi more, N 20e. Method of Disposition 20b. Pleca of Disposition (Neme of Dale 20c. Location - City or Town							
Baltimore,	pemit. Pages Department of I Important: If Ite any injury or of ange.	1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signalure of Funeral Service Hoense 22. Name and Addrass of Facility BEARD FUNEVAL HOM Q							
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or co shock, or heert failure. List onl Immediate Ceuse (Finel disease or condition resulting in death)	· Multiple	. Do not enter tha mode of Gunshot	Cewil's s dying, such as cardia	c or raspiratory e	me de	Approximete Intervel Between Onset end Deeth	0
Division of Vital Records, P.O	death certificate be executed a ettending physician and of for use as the burlet-transit sician/Medical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of):							
	d by the letech	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 28 No 3 Probably 4 Unknown							
	S 2 G					24a. Wes	en eutopsy ormed?	24b. Were eutopsy finding eveileble prior to completion of cause of deeth?	S
	The law sate hes page 2					121 Yes 2□No 126 Yes 2□I		187Yes 2□ No	
	octor Be	25. Was case referred to medical exeminer?	26. Pleca of Deeth (Check only one) Hospitel: 1 Januariset 2 EP/Outgriget 2 DOA Other: 4 Aurelea Name 5 Desiring 5 Other (Specific)						
	유 부 등	1 No 2 No 2 No 27. Manner of Deeth	28e. Dete of Injury 28b. Time of 28c. Injury et			Home 5X Residence 6 □Other (Specify) 28d. Describe how Injury occurred			
	th. The three strong the three strong three	1 ☐Netural 5 ☐ Pending 2 ☐ Accident investigati	(Month Day Year)	, M	Work? I ☐ Yes 2,87 No				
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not determine	/ II IO WINNOW!		fice	Subject was shot 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 730 Lennox St Baltimore City, Maryland			eet
	To the Hospital within 24 hours a To the Funeral Completely filled								
	thin 2 the bomplet	one)	end menner steted.		cense number				
	or vie	29b. Signeture end title of certifier	A MAnie		C.M.E			2,1998	
	1	30. Name end eddress of person who	completed cause of daath (Item	23a) (Type, Print)					

State Registrar orn S, Radentz, 111 Penn Street, Baltimore, Maryland 21201

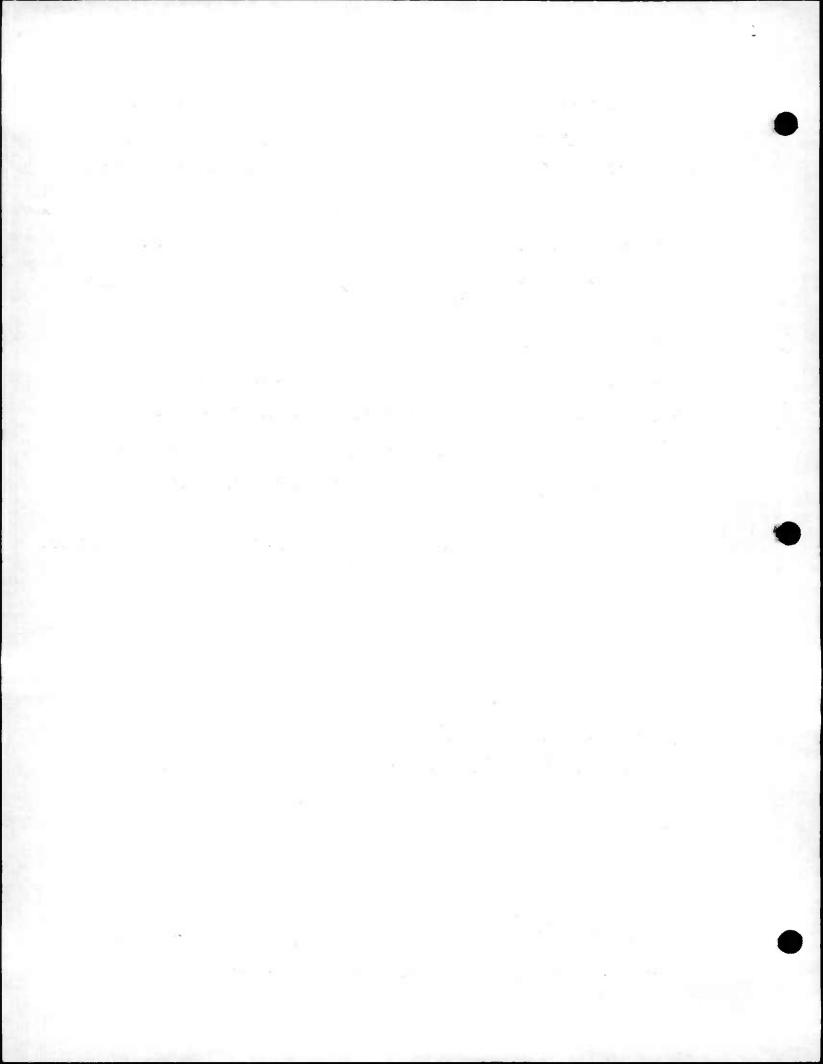


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** George E. Brooks July 10 1998 5:35PM/Medical 4c. County of Deeth 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner The Memorial Hospital Easton Talbot 8. Date of Birth Month, Day, Year 03/24/1920 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 156 M 2□ F Days Hours Months 78 Yrs. Director 217-10-3853 Maryland Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. fnside City Limits traumetic event, the Medical Examiner must be notified at Md. Talbot Wittman Director 1 ☐ Yes 2 No or 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21676 U.S. 8000 Tilqhman Is. Rd. permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e any injury or other traumatic event. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Black 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1945 1 ☐ Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) Forge Contractor none Industry 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Be Blanche Palmer James Brooks 19a. Informant's Neme/Relationship (Typa, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) 8000 Tilghman Is. Rd. Wittman, Md. 21676 Irene May Brooks 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ■Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. James Cem. 7/17/98 Sherwood, Md 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility 322 East Ave. Easton, Md 21601 ashioll Sur 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) Vousmal Cell lung Cancer /Medical Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last the burial-tran Due to (or as e consequence of): Box 68760, the ettending physician thed for use es the buria Completed by Physician/Medical Due to (or es e consequença of): P.O. deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 8 Excelar disease 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy peeu has Erelnovorcelar desease certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: director. 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 1 ☑ Naturel Dete of fnjury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred : After ! Division 5 Pending Investigation s efter death.

I Diractor: Aft
of In by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Hospital To the Hospital within 24 hours e To the Funeral Completely filled pelli 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Yaar) 29b. Signatura and title of certifies 29c. License number 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) David H. Smith 509 Idlewild Ave. Easton, Maryland 21601 32. Registrar's Signature 31. Dete filed (Month, JUL 1 3 1998 State

DHMH 16 Rev 6/95

Registrar



WRC 98-3941-035 FRANK L. **BEAVER**

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Marvland / Department of Health and M

Health and Mental	Hygiene	00	23	100
Death	Reg. No.	30	20	13:

29d. Date signed (Month, Day, Year)

JULY 10, 1998

	ľ
Physician	
/Medical	_
Examiner	4

Funeral

Director permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-1 show shipury or other traumatic svent, the Medical Examinat must be notified at Page.

Physician Examiner

Physician/Medical Examin Be Completed by

Baltimore, Maryland 21215-0020 To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, La	st)						2. Date of De Month		Year	3. Time of Death
FRANK	LARSON		BEAVER				JULY (Day 1998		2:31 pm.
ta Facility Name (If not institution, giv		oer)	DLIIV	LIK	4b. City, To	wn, or Lo	ocation of Deat			
RT.301 AND ROL	LING BRI	DCE RE	,		CENT	ז מישיו	ILLE	OHEE	NI ANINIE	
5. Social Security Number 6. S	-		last birthday)	If Under 1 Ye	ar If Under	24 Hrs.	8 Date of Bir	th	9. Birthplac	e (State or Forei
213-16-8079 A	₩ 2□ F	77	Yrs.	Months Day	s Hours	Min.	(Month, De	9, Year)	Country	FORNIA
Usual Rasidenca of Dacedent							OIIIV 2	, 1721	OHLI	COLUMN
10a. State 10b. County		10c. Cit	y, Town or Loca	ation					10d	. Insida City Limit
MD OUE	EN ANNE		CENTRE	VILLE						1 ☐ Yes 2 N
10e. Street and Number	SIL THINE		OHITICH	10f. Zip Code				10g. Citizen of N	What Country	17
1320 HOPE ROAD					1617			USA		
11. Manital Status	12. Was Decede	ant Ever in U	S. 13 W			gin? (Sp	ecify Yes or No		a - American	Indian.
1 Never Married 2 Married	Armed Force	es?	If	res, specify C	ıban, Maxicar	, Puerto	ecify Yes or No Rican, etc.)	Bla	ck, White, etc	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1[Yes XXI	o Specify:			Specify	y:	WHITE
			16a Decede	nt's Usual Occ	unation			16b. Kind of B	usingss/Indus	stry
15. Decedent's Education (Specify only highest gradual)	ide completed)		(Give ki	nd of work do NOT use ret	ne during mos	t of work	ing			
Elementary/Secondary (0-12)	College (1-4	or 5+)						DAIRY		JULIKI
9 17. Father's Name (First, Middle, Last			FARME	I.	18 Mothe	r's Name	a (First Middle	FARMIN Maiden Suman		
IN B CONTRACTOR OF THE STATE OF										
WILLIAM JAMES BEA			I NOT THE REAL PROPERTY.				IAE CLA			- Vis
19a. Informant's Name/Relationship (7	_					er, City or Town,		ode)
CATHERINE S. BEAV	EK/ WIFE				DAD, CE	MIKI	SVILLE,	MD 2161	1/	
Oa. Method of Disposition	10		Place of Disposi cemetery, crema		lace)		Dete	20c. Location	- City or Town	n, State
1 N Buriel 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specil 21. Signature of Funeral Service Licar 23a. Part1. Enter the disease, or comshock, or haart failure. List only	nsee On FR C	CHE	STERFIE FEL FEL	LD CEMI Name and Ad LOWS, I	ETERY tress of Facilit IELFENE IBERTY	SEIN ST.	& NEWN	REVILLE.	RAL HON	ME, P.A.
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State Registrar

29b. Signature and title of certifier

Stephen S.
31. Data filed (Month, Day, Year) adentz

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrats Signeture

Julia Davidson-Randalas

29c. License number

O.C.M.E.

DHMH 16 Rav 6/95

APP 400 PR 100 PR PARTICIPAL TO SEE THE TABLE THE THE PERSON OF THE PARTY OF l Describeration de la communication de la Colonia. Un la colonia de la coloni

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month **Physician** Dorothy Eileen Clough 7 1998 7:25PM July /Medical 4a. Facility Name (If not institution, give street and number) Meridian—
Genesis Eldercare of Corsica Hills
Home

5. Social Security Number

6. Sex

7. Aga (In yrs. last birthday) 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** Centreville Queen Anne's if Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Under 1 Year Months Days 8. Data of Birth (Month, Day, Yaar) Birthplace (Stata or Foreign Country) **Funeral** 216-09-4723 1 M XXF 80 Director Nov. 4,1917 Maryland Usual Rasidance of Dacedent the Marylend 10a. Stata Md. 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23e or 28a-f show traumetic event, the Medical Examiner must be notified at Queen Anne's Chester Director 1 ☐ Yas 2K No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 1335 Queen Anne Drive 21619 U.S.A. naturel', or items 23e Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican indian, Bleck, White, atc. permit. Peges 1 end 2 should be filed within 72 hours after a Department of Health end Mental Hygiene. Important: if Item 27 Is marked other than "naturel", or iten any Injury or other traumatic event, tra Medical Evanties. 9058. 1 ☐ Yas 2 [X] No If Yas, Giva Yaar or Dates: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 🏋 No Specify: by Specify: White 35 Wodowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Homemaker Self 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Leola Saddler Frank Clevenger 19a. Informant's Name/Ralationship (Type, Print) Daughter 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Steta, Zip Coda) Mrs. Bonnie Pierson 1506 Calvert Rd., Chester, Md. 21619 July 18 ata 1998 Co. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatery, crematory or other place) X Buriai 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Stevensville Cemetery Stevensville, 21. Signature of Funeral Service Lice 22. Nama and Addrass of Fecility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd., Chester, Md. 21619 **Physician** Immediata Cause (Finel disaasa or condition resulting in daath) Pheumonia /Medical luk Examiner Dua to (or es a consequance of): Intrace buriel-transit The law requires that the death certificate be executed Exami Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury pue Due to (or es e consequance of) ettending physician for use as the buriel P.O. Box 68760, Physician/Medical that initiated events rasulting in daath) Lest Due to (or as a consequence of) use as Part II. Other aignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ete hes been signed pege 2 should be de Records, ģ 24b. Wera autopsy findings eveilabla prior to complation of cause of daath? Completed 24a. Was an autopsy this certificate 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Place of Death (Chack only one) Othar: 4 Rasidance 6 Othar (Specify) 1 Yas 2 → No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28c. Injury at Work? 28a. Dete of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how Injury occurred After Natural 2 ☐ Accidant 5 Pending investigation Injury To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 ☐ Sulcida 28e. Plece of Injury - At homa, farm, streal, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 4 Homicida cal 29a. Cartifian 12 Cartifying Physician: To the best of my knowladge, deeth occurred et the tima, data and place, and due to the ceuse(s) and mannar as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and manner statad. (Check only one) 29b. Signatura and the of pertifier 29d. Data signad (Month, Day, Yaar) 29c. Licansa number 30. Name and address of person who completed causa of daath (Item 23e) (Type, Print) Donah Drive Charle-, MD 21619 2608

32. Ragistrar's Signeture

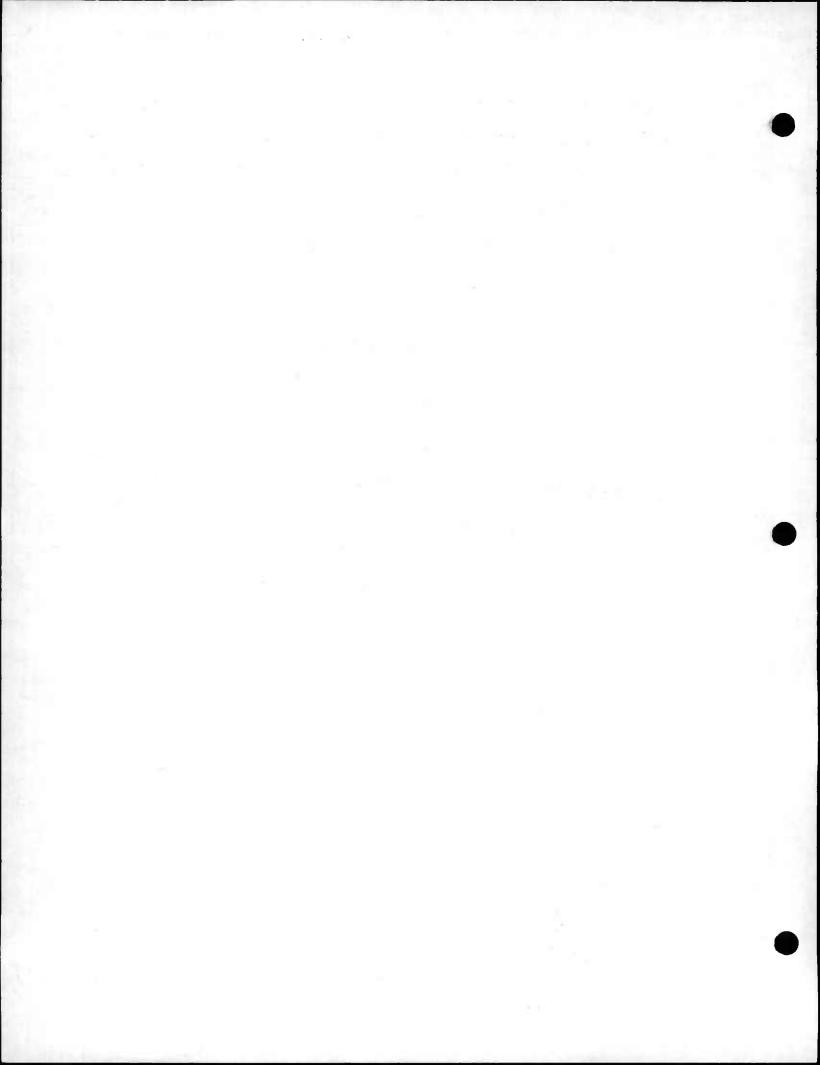
I Julia Davidson-Randall

Registrar

State

31. Data filed (Month, Day, Year)

0 1 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name /First Middle, Last) 2. Date of Death 3. Time of Deeth 1:04AN 4a. Facility Name (If not institution, give street and nurgber) 4b. City, Town, or Location of Death BAHimore ne 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Days Months 217-22-4810 1□M 200 F Hours Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits HAREORL Yes 2□No Edgewood 10f. Zip Code 10g. Citizen of What Country? 433 21041 454 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify Black Specify: 3 Widowed 4 □ Divorcad Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 estauron Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) E Williams BRANder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, Stete, Zip Code) 1 homas Epps 20a. Method of Disposition 20000 J. MD 21040 20b. Place of Disposition (Name of cemetery, cremetory or other place 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 5 ☐ Other (Specify) ewis m1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Carcinoma 6 unos Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 donknown

Physician /Medical Examiner

permit. Peges 1 end 2 sh Department of Health and Important: If Itam 27 is m any Injury or other traum once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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Itams 23a

Peges 1 and 2 should be filed within 72 hours after on ont of Health and Mental Hygiene. Int: If Itam 27 Is merkad other than "natural", or Ital

Baltimore, Maryland 21215-0020

traumatic evant, the Medical Examiner must be notified at

by Funeral

Completed

Be

buriel-tran as the for use as ed by the a signed b director, funeral

The law requires that the deeth certificate be executed

certificate has

this

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physiclan/Medical Examine þ Completed Be P Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an eutopsy performed'

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 40 501 C.B. 28d. Describe how Injury occurred

1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifiqu 29c. License number M

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of

Hospital:

5 Pending Investigation

6 Could not be determined

(Item 23a) (Type, Print)

11 MI) 858 N. Eutau (KOBEN

31. Date filed (Month, Day, Year) 0 9 1998 Registrar

25. Was case referred to medical examiner?

1 Yes 2 No

27. Menner of Deeth

1 Natural

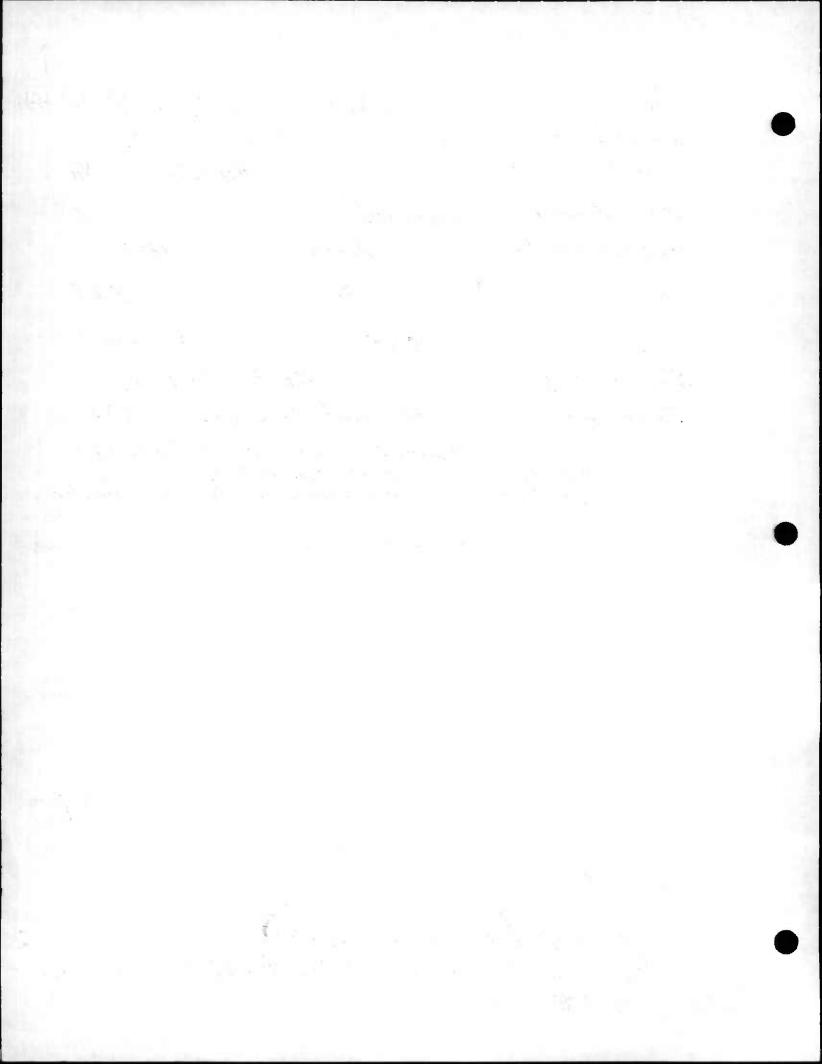
2 ☐ Accident

3 ☐ Suicide

4 ☐ Homleide

3. Registrar's Signature

DHMH 16 Rev 6/95



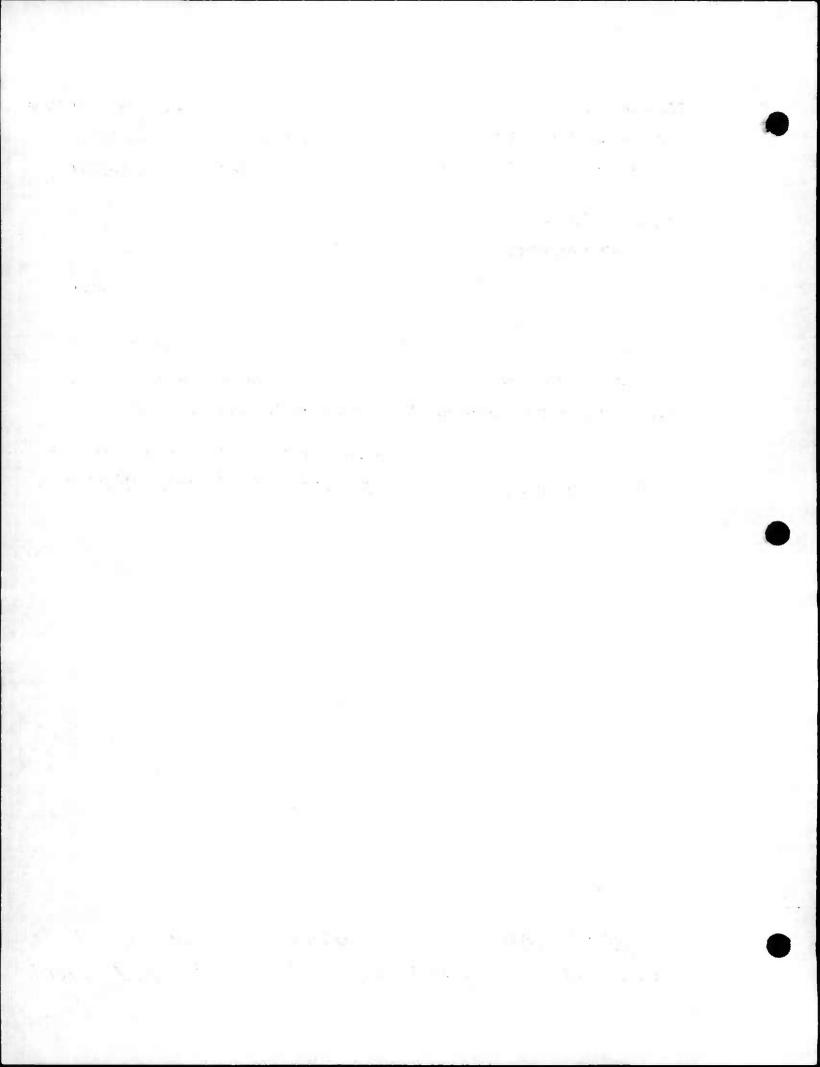
State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 449 **Physician** Florence Anne AM 13 1998 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Harford Bel Air Mariner Health of Bel Air If Under 1 Yeer If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplece (Sta Nov. 18, 1908 Mary Land 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Hours Months 1□M 20 F Vrs 89 **Director** 215-10-4330 Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or items 23s or 28s-f show the Medical Examiner mant be notified at 1 ☐ Yes 2 ☑ No Director Maryland Bel Air Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21015 IISA 413 Amelanchier Ct. Funeral 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes. 2% No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marltei Stetus 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☐ No Specify: À Yes Give Specify: 3. Widowed 4 □ Divorced Yeer or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) permit. Peges 1 and 2 should be filed with Department of Heelih and Mantal Hygiene, important: if Item 27 is marked other that any injury or other treumatic event, the Agage. Own Home 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Florence Bell Miller Vincent Edward Cross 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
413 Amelanchier Ct., Bel Air, MD 21015 Mary Ellen Blackburn /Daughter 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens 7-16-98 Bel Air, Maryland 21. Storydure of Funeral Service Licenses 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. mas 1317 Cokesbury Road, Abingdon, MD 21009 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical Urosepsis 7 days Examiner Due to (or es e consequence of): attending physician and for use as the burial-trens Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? hes this certificate 1 Yes 2 No 1 Tyes 2 No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) P₀ 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred Aftert Certification: 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner attend. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Yeer) D34452 July 13, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Avenus Byl Air Manyland 21014 2 North #2 Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

Florence A. Crue



		State	of Maryland / Depa Cea	artment of rtificate of			iene 98
Physician /Medical	Dacedant's Nama (First, Mid EDWARD	JOSEPH	CARLIN, S	R.		2. Date of Dea Month JULY	13 199
Examiner	4a Facility Name (If not institut THE MEMORIA	ion, give street end n			4b. City, Town	n, or Location of Death	4c. County o
Funeral Director	5. Social Security Number 180-07-6945	6. Sex 1XXXM 2□ F	7. Age (In yrs. lest birthday) 83	Months Days		Min. 8. Date of Birth (Month, Day MAY 16,	Year) 1915

	State of N	naryland .	Departm Certific		Health and N Death		giene (Reg. No.	98 3	2320	3
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						Month	Day	Yaar		
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4a Facility Name (If not institution	n, give street end numbe	r)			4b. City, Town, or L	ocation of Death	4c. Co	unty of Death	n	
THE MEMORIAL	L HOSPITAI				EASTON		TA	LBOT		
5. Social Security Number 180-07-6945	6. Sex 1XXM 2□ F 8	ige (In yrs. lest	Yrs. If Ur Mont	nder 1 Yea hs Days		8. Date of Bird (Month, Da MAY 16		Col	nplace (State ountry) NNSYLVA	
Usual Residence of Decedent										
10a. State 10b. County		10c. City, T	own or Location						10d. fnside Ci	ity Limits
MD	TALBOT	1.3	EAS	TON					1XXVes	2 □ No
10e. Street and Number			10f.	Zip Code			10g. Citizen	of What Co	untry?	
2 COLONIAL CO	URT			21	601			USA		
11. Marital Status 1 Never Married 200 Marr. 3 Widowed 4 Divorced	If Yes,	If Yes, specify Cuban, Maxicen, Puerto Rican, etc.)					4. Race - American Indien, Black, White, etc. Specify: WHITE			
15. Decedent (Specify only highes	s's Educetion of grade completed)	1	6a. Decedent's U	Jsual Occu	pation during most of worked)	king	16b. Kind	of Business/	Industry	
Elementary/Secondary (0-12)	College (1-4or	5+)	CARPE		90)		INDUS	TRIAL	CONSTRU	UCTION
17. Fathar's Name (First, Middle,	Last)		Ollitz L	212.221	18. Mothar's Nam	na (First, Middle,	Maidan Su	meme)		
JOSEPH CARL	IN				JOSEPH	INE MUR	PHY			
19a. Informant's Name/Raiations	hip (Type, Print)		19b. Mailing Add	rass (Strae	t end Number or Ru	ral Routa Numb	er, City or To	own, Stete, Z	(ip Code)	
EDWARD J. CARLI	N, JR./ SON		257 WEST	PARK	LANE, CLI	FTON HE	IGHTS	, PA 1	9018	
20a. Method of Disposition 1 Buriat 2XX remation 4 Donation 5 Other (S)		20b. Plac cem	e of Disposition (etery, cremetory APEAKE C	Nema of or other pl REMA	TION CTR	7-14		ion - City or ER, MD		
21. Signature of Funeral Service	In I		FELL	OWS,	ess of Facility HELFENBEI ARRISON ST				_	P.A.
23a. Part1. Enter the disease, of shock, or heart failure. List fmmediate Cause (Final disease or condition resulting in death)				noda of dy					Approximat Interval Bat Onset and	ween Death

Physician /Medicai Examiner

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health end Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show vary injury or other traumatic event, if Medical Experient must be notified at pince.

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end of for use as the bunal-transit within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be deteched. by Completed Be Certification: To

Division of Vital Records, P.O. Box 68760,

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): Dua to (or as a consequenca of)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTHYROIDISM

Due to (or as a consequence of) HYPERTENSION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown

OSTEOPOROSIS	
SETZURE	

24a. Was an autopsy performed?

1 Yes 2 No

JULY

24b. Were autopsy findings available prior to completion of ceuse of death? 1 TYes 2 TNo

YEARS

YEARS

YEARS

25. Was cese rafarred to medical		26. Placa of Death (Check only ona)							
examinar? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Other:	4□ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify,				
27. Mannar of Death 1	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?		I. Dascribe how injury occurred				
3 ☐ Suicida 6 ☐ Could not determine		noma, farm, strea	t, factory, office	281.	Location (Street and Number or Rural City or Town, State)				

Routa Number 29a, Certifier 1X Certifying Physician: To tha best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b.	Signature	and	title	of	certifier		
					- /		

29c. License number D 46020

29d. Date signed (Month, Dey, Year)

13, 1998

30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

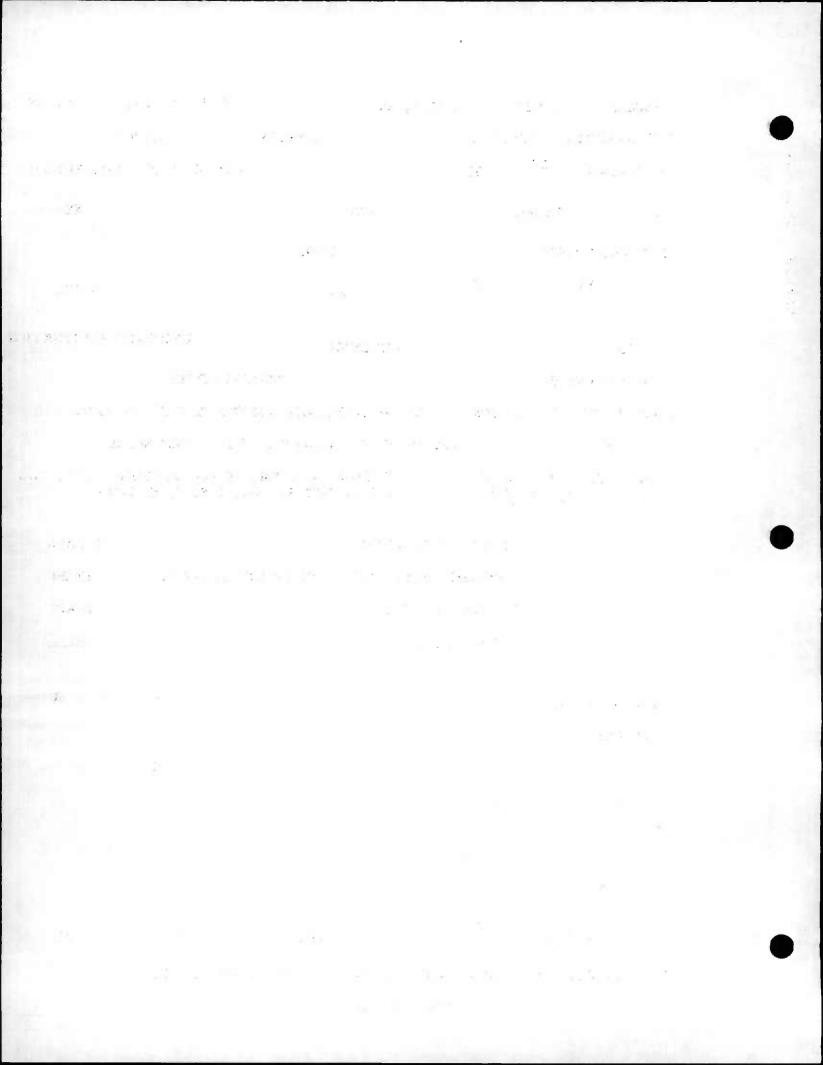
SYED I. ALI 31. Date filed (Month, Dey, Year) JUL 1 4 1998

506 IDLEWILD AVE. EASTON, MD 21601

State Registrar

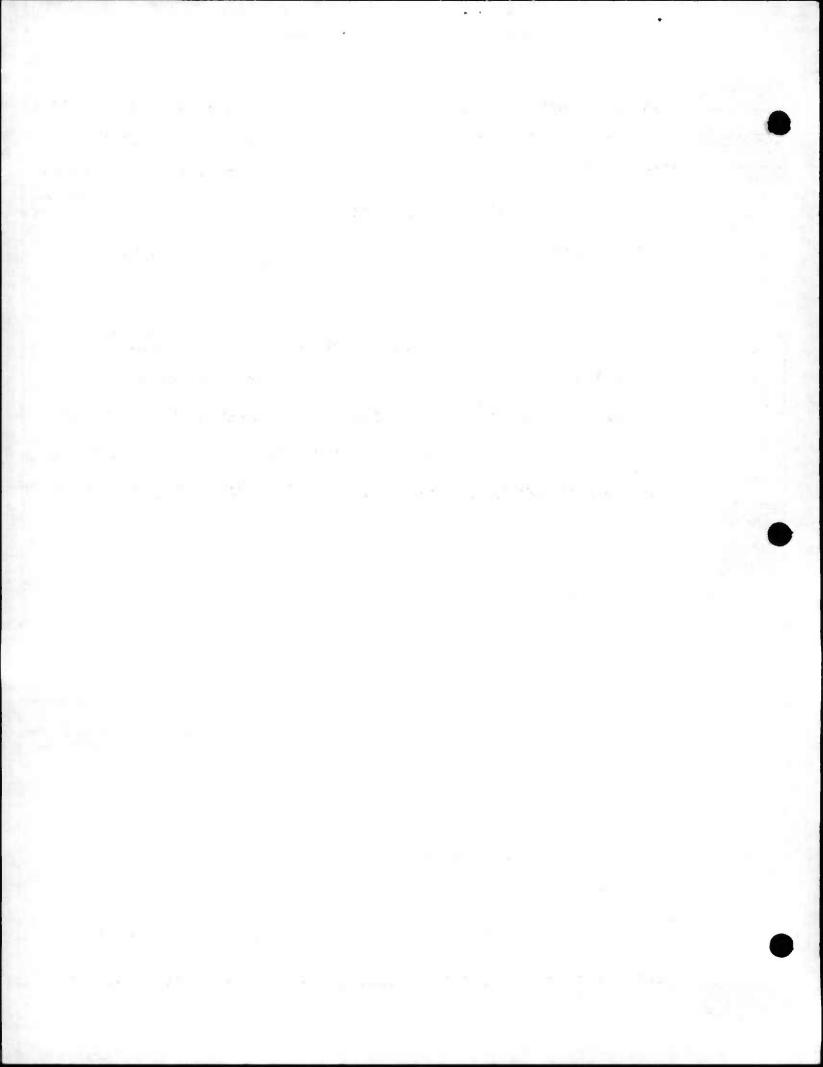
Medical

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23204

Director Second	
Fundamental	3. Time of the
## County of Dear Part As Facility Name (Incoming home steel and number) As Facility Name (Incoming home) As County of Dear As County of D	8:13 A
Memorial Hospital of Easton Talbo Fundral Social Security Number 218-20-6817 10M & XX 7. Aga (b) yz. Nast birmday) 10M of 17 law 1	
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Middle) 18. Mother's Name (First, Mi	-
17. Father's Name (First, Micdic, Last) 18. Michae's Name (First, Micdic, Last) 19. Michae's Name (First, Micdic, Micdic) 19. Michae's Name (First, Micdic) 19. Mich	
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23a Part Enter the sease, or complications that caused the dearly Do not enter the mode of dying, such as cardiac or respiratory arrest, incided in the sease or conditions as a consequence of condition resulting in death) 24a	unawal H
Impediate Cause (Final disease or conditions as a consequence of): Cause (Final disease or condition exiting in death) Due to (or as a consequence of):	uneral H
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Due to (or as a consequence of): Command	11
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initied events resulting in death) Last Due to (or as a consequence of): C. CONVACY ALLY DUE 10 (or as a consequence of): C. CONVACY ALLY DUE 10 (or as a consequence of): Due to (or as a consequence of): 1 Yes 2 Two 3 24e. Was an autopsy performed? 25. Was case rafarrad to medical examiner? 1 Yes 2 Two 3 27. Manney Death 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S) 28. Date of Injury 28d. Location (Street end Number or injury of the property of	sudder
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d. Chock repaired for the underlying cause given in Part I. Chock repaired for the underlying cause given in Part I.	
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28e. Plece of Injury - At homa, farm, street, factory, offica 28f. Location (Streat end Number of City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, offica 28f. Location (Streat end Number of City or Town, Stete) 28g. Plece of Injury - At homa, farm, street, factory, offica 28g. Plece of Injury - At homa, farm, street, factory, offica 28g. Location (Streat end Number of City or Town, Stete) 29a. Certifier (Check only one)	
29a. Certifier (Check only one)	Route Number,
29a. Certifier (Check only one)	
	as stated. ue to the cause(s)
29b. Signature and title of certifiar 29c. Licensa number 29d. Date signed (Mc	nth, Dey, Year)
D1/21, 27 July 24	
79162	1 7 7 0
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	
Kathleen Hoey, M.D.; 2540 Centreville Rd., Centreville, Md. State 31. Date filed (Month, Dev Level 27 199832. Registration days fonder).	21617



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 16 July 1998 7:15a.m. JOE R. DOUPNIK /Medical 4b. City. Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner The Memorial Hospital Easton Talbot If Under 1 Yeer | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Ye DEC . 24, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiace (Stete or Foreign **Funeral** Days Yeer 1 M 2 □ F 1913 CZECH REPUBLIC Vrs 84 Director 478-18-5281 Usuei Residence of Decedent with the Merylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health end Mentel Hygiene. Important: or items 23a or 28a-f show important: if item 27 is merked other than "naturel", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at abotes. CORDOVA MD TALBOT 1 Yes 2 No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 11551 KITTY'S CORNER ROAD 21625 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American indian Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1□ Yes 2√XNo Specify. Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CONSULTING PRACTICE Eiementary/Secondary (0-12) College (1-4or 5+) IN ACCOUNTING ACCOUNTANT 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be JOSEPH DOUPNIK ANTONIE BODLAK 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11551 KITTY'S CORNER RD., CORDOVA, MD 21625 DARRELL B. DOUPNIK/ SON ltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Mariai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-20-98 EASTON, MD SPRING HILL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERON CFS 200 S. HARRISON ST., EASTON, MD 21601 JOHN R. Approximate Intervel Between Onset and Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical ews diser a Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last buniel-trer Due to (or es e consequence of) P.O. Box 68760. physician Physician/Medical the Due to (or as a consequence of) USB 85 ettending for Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown rullitin Records, à 8 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy page 2 should Completed been performed? hes 2000 this certificate 1 Yes 1 Tyes 2 No Division of Vital Hospital or Attending Physician: director. Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigation 1 Neturel Injury efter deeth. 1 Tes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours e 1 Cartifying Phyeictan: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. edical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and little of certifie 29c. License number 8 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

> DAVID G. OLIVER, M.D., 503 DUTCHMAN'S LANE, EASTON, MD 21601 32. Registra's Signature
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> Funa Dandson-Randall

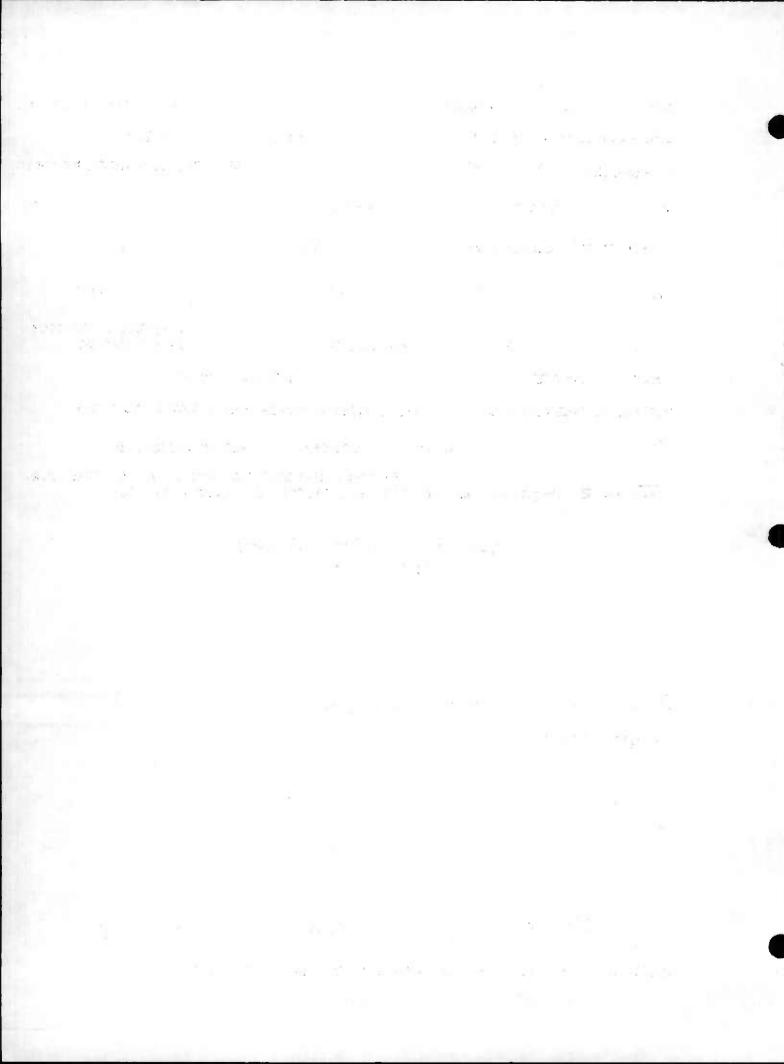
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State

31. Date filed (Month, Day, Year)

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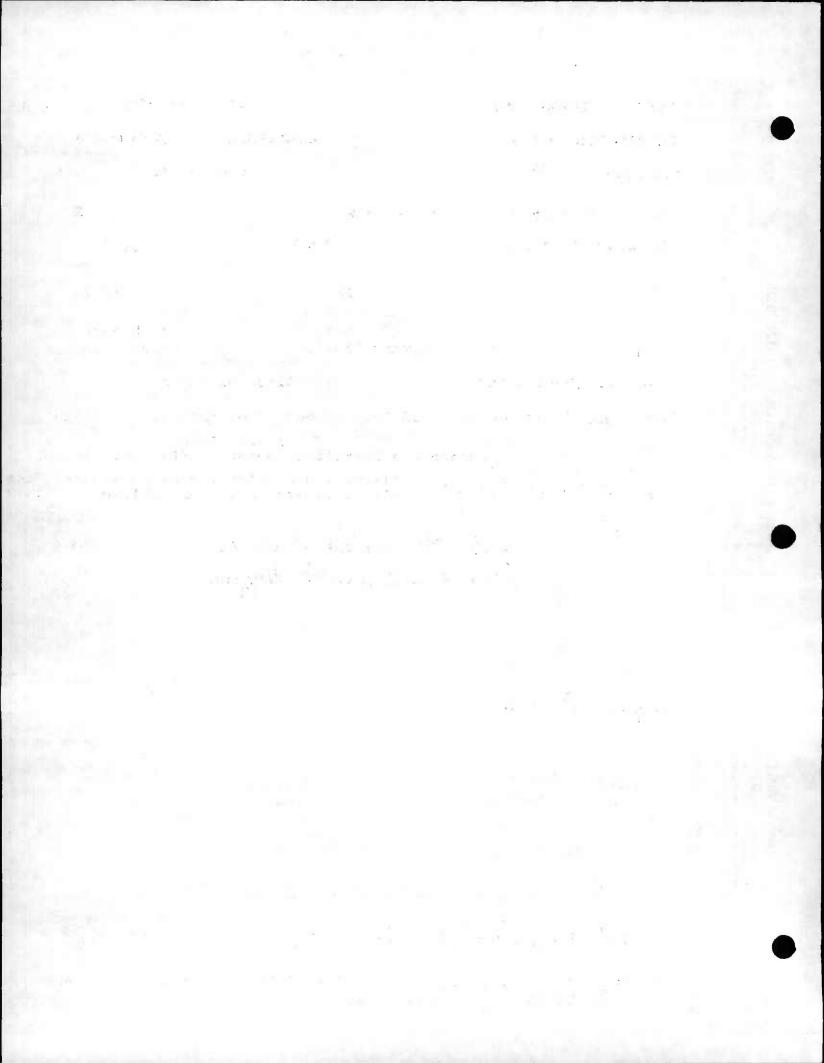
. Doupnik



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician JULY 19 1998 LLOYD TILGHMAN EMORY 11:50 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** QUEEN ANNE'S CENTREVILLE 205 BROADWAY, APT. 4 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 2□ F Yrs. Director 179-22-3242 Usual Residence of Decedent Dec. 2, 1926 the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD OUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21617 205 BROADWAY, APT. 4 U.S.A. items 23s Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1√√Yes 2 □ No 11 Yes, Give 11. Maritat Status Black, White, etc. filed within 72 hours efter M Never Married 2 Married Saltimore, Maryland 21215-0020 'natural', or 1 Yes X No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates 16e. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. North West Elementary/Secondary (0-12) College (1-4or 5+) Horticulturist Point Farm 12 permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important; If flam 27 is marked other any Injury or other traumatic event RDEs. 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Lloyd Tilghman Emory Alice M. Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Howard Wood/ 2nd Cousin 306 Kent Street Chestertown, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 21, 1998 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Chesapeake Cremation Center Stevensville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Fecilit Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St. Cen: Centreville, MD 2161 23a. Part1. Enter the Usease, or complications that ceused the shock, or hear/reflure. List only one cause on each tine. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner certificate be executed buriel-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Records, P.O. Box 68760. physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) the USB BS ed by the e Part IL Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown umuri þ 8 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed page 2 s certificate has 1 ☐ Yes 2 DINO 1 Yes 2 No Division of Vital at or Attending Physician: T s efter death. I Director: After this certificet director, Be 25. Was case referred/to medical 26. Plece of Deeth (Check only one) examiner's Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes/ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 PNaturat 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) yd ni bellii 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

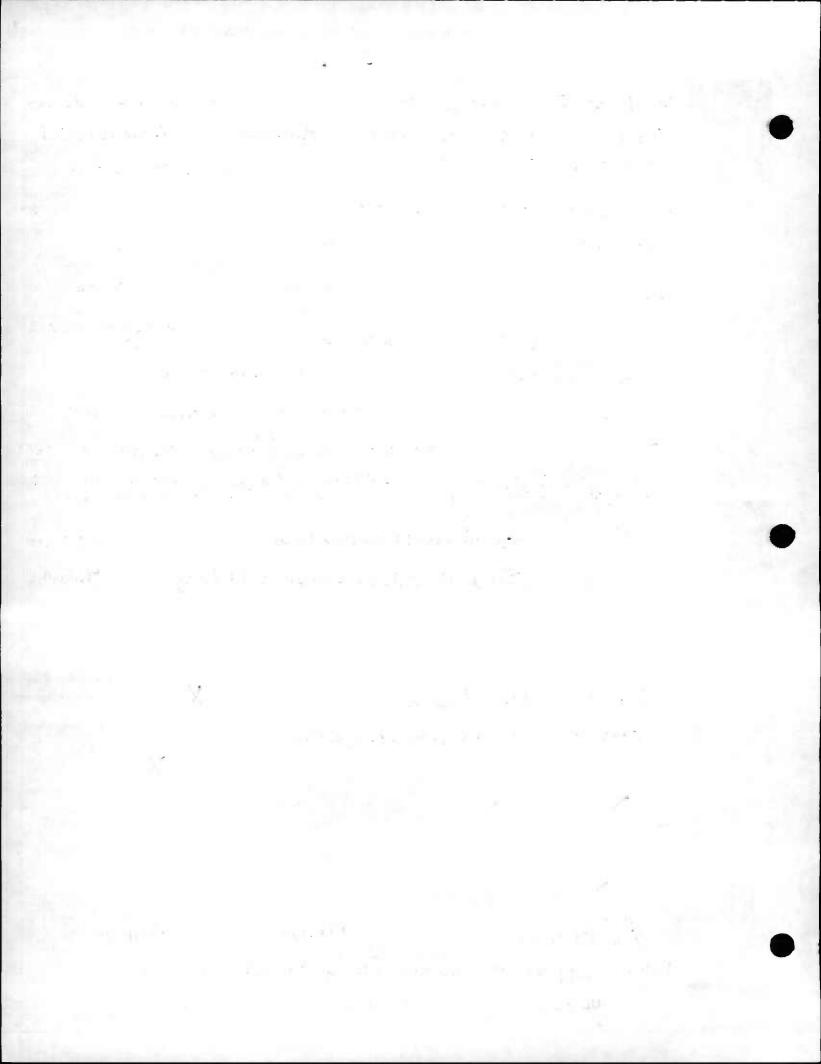
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. To the Hospi within 24 hou To the Funer completely fil 29a, Certifier edical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of pertifier 30. Name and address of parson who completed cause of dead (Item 23e) (Type, Print) Dr. William H. Wood
31. Date filed (Month, Park Year) 4 200 32. Regign M D 506 Idlewild Avenue Easton, MD 21601 Arar's Signature State "JUL"21 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene 98 23207

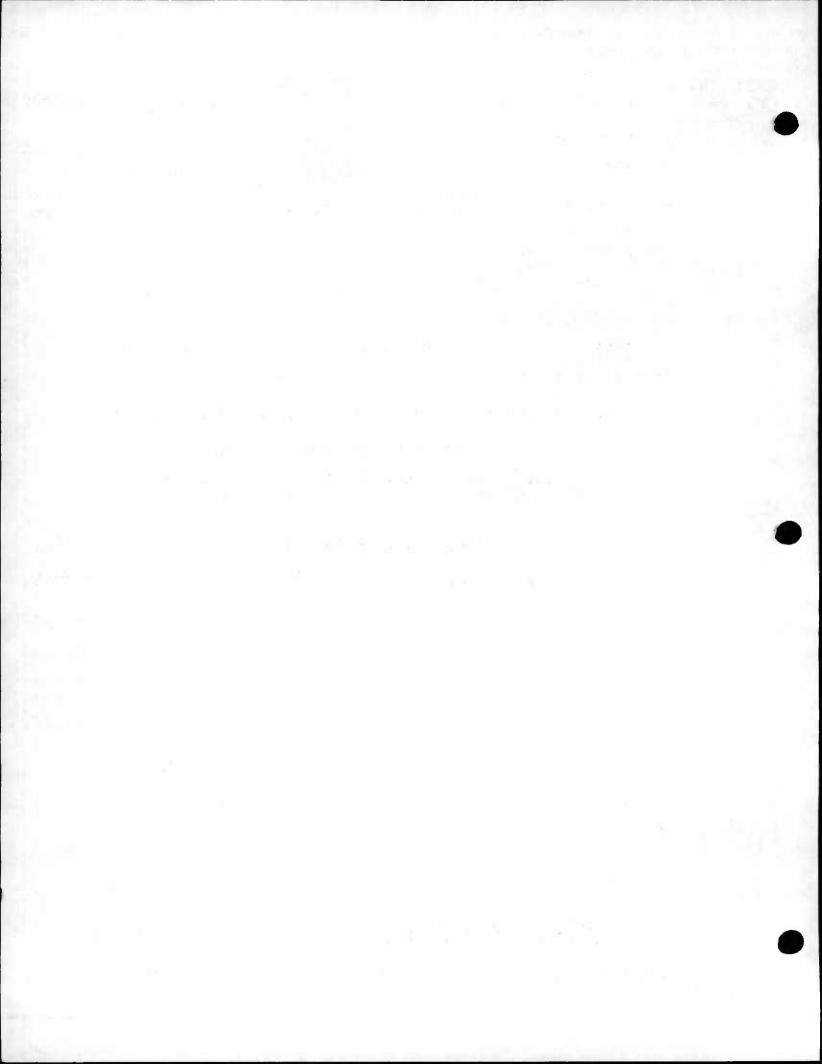
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State of Maryland / Department of Health and Mental Hygiene

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Hospital 24 hours Funeral stely filled	edicai	29a. Certifier (Check only	1 Cartifying F	hysician: To the	e best of my	knowledge, death ninetion end/or in	occurred et th	e tim	e, date end pla	ece, er	nd due to the	ceuse(s) end m	enner es s	steted.
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Funeral Director	5. Social Security Number 155-46-5769 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	ge (In yrs. lest birti	hday) If Under 1 Yea Months Dey		Min. (Month, De	8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (State Country) Feb. 21, 1951 Pennsylvar			
Meryland	10a. Stete 10b. County	rford	10c. City, Town	or Location				100	d. Inside City Limits 1 ☐ Yes 2 ☑ No	
oth with the Me 23s or 28s-fs		e Apt.	21040			ISA				
is 1 and 2 should be filed within 72 hours efter deeth with the Meryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	3 ☐ Widowed 4 ☑ Divorced	H Vac Civa	?	13. Wes Decedent of if Yes, specify Control of the second		in? (Specify Yes or N Puerto Ricen, etc.)	o- 14. Rac Blec	e - America ck, White, et Whi	ic.	
	15. Decedent (Specify only highes Elementery/Secondary (0-12)			Decedent's Usuel Occ (Give kind of work dor life. DO NOT use reti	upetion ne during most (ired)	of working	16b. Kind of Bo			
		lard 18. Mother	Y							
1 and 2 should be filed with Heelih and Mentel Hygiene. em 27 is marked other than other traumatic event, the Mentel Hygiene.	Francis M. Hop	Francis M. Hopely Elean								
and 2 sh lith end 27 is m r traum	19a. Informent's Name/Reletions! Francis Hopely/			Mailing Address (Stree 36 Evergre						
800 = 8	20a. Method of Disposition 1 Buriel 2 Cremetion	20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other					20c. Location -	City or Tow	n, Stete	
pemit. Pag Daparment Important: I eny injury o 2058.	21. Signature of Funerel Service I	icensee I. Emy A	ial Park 7-16-98 West Deptford, NJ 08 ddress of Fecility d K. McComas III Funeral Home, P.A. Cokesbury Road, Abingdon, MD 21009							
Physician /Medical	23a. Pert1. Enter the diseese, or shock, or heart fellure. List Immediate Ceuse (Finel diseese or condition			eriosclero	lying, such es c	ardiec or respiretory	errest,		Approximete Intervel Between Onset end Death	
Examiner	resulting in death)	any per cen	Due to (or es e c		Lic car	atovascure	n Discu	50		
be executed sician end buriel-trensit		b								
leath certificate be attending physicis	resulting in deeth) Lest	d	Due to (or es e ca	onsequence of):						
res that the death certification of the detached for use the detached fo	Part II. Other significant conditio	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.							the cause of death?	
aw requires the state of the st									re eutopsy findings liable prior to ipletion of cause seth?	
the li									Yes 2□ No	
sician: The certificate lirector, pa	examiner?	of Death (Check only	th (Check only one)							

Division of Vital Records, P.O. Box 68760

To the Hospital or Attanding Physi within 24 hours efter deeth.

To the Funeral Director: After this o completely filled in by the funeral dir

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner stated.

28c. Injury el Work?

1 Yes 2 No

O.C.M.E.

29b. Signeture end title of certifier

28e. Dete of Injury (Month, Dey Year)

29d. Date signed (Month, Day, Year) 29c. License number JULY 12,1998

28d. Describe how injury occurred

28t. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 250) (Type, Print)
Stephen Radentz, M.D.
111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical Certification: 1

27. Manner of Death

1 Neturel
2 Accident

3 Suicide

4 Homicide

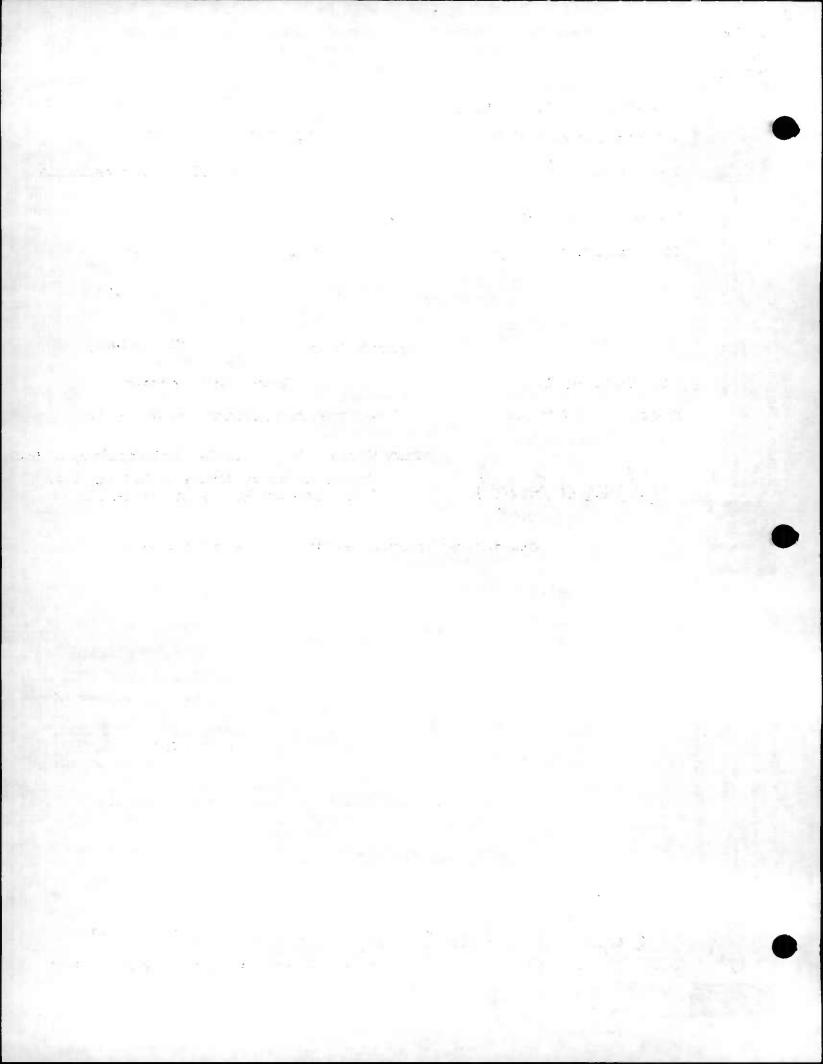
5 Pending investigation

6 Could not be determined

31. Date filed (Month, Dey, Yeer)



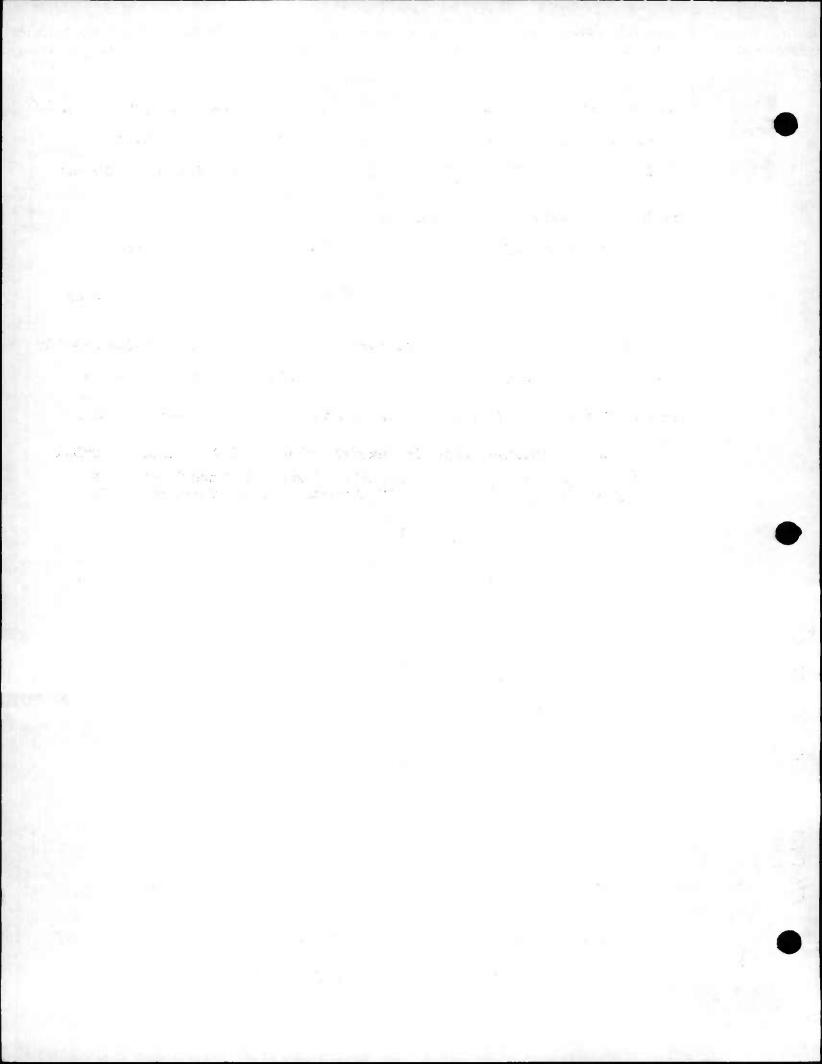
28b. Time of injury



State of Maryland / Department of Health and Mental Hygiene 23210

				Ce	ertificate	of Death		Reg. No.		
Dhamia		1. Decedent's Neme (First, Middle, Las	st)				2. Date of De Month	ath Dev	3. Time of Deeth	
Physici /Medi		FRANCES MARIE	HORMES				July	11 1	998 062	
Examir		4e. Fecility Name (If not institution, give	e street end number)	100	-2	4b. City, Town, o	Location of Deetl	4c. County	of Deeth	
		Fallston General	Hospital			Fallst	on	Hari	ford	
Funeral		Social Security Number 6. Social Security Number		. lest birthday		Year If Under 24 Hr Deys Hours Min		th Year)	9. Birthplece (State or Fore Country)	
Director		218-12-8863 Usuel Residence of Decedent	□ M 2 X F 7	4 Yrs.	Months	Deys Hours Mil	Apr. 5	1924	Maryland	
n 72 hours efter death with the Maryland "natural", or items 23a or 28a-f show		10e. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Lim	
	ţō	Maryland Harf	bro	Bel A	ir				1 ½ Yes 2□	
	Director	10e. Street end Number	524	201 11	10f. Zip C	ode		10g. Citizen of W	Vhet Country?	
		108 North Lynbrool	k Road	2	1014		_	JSA		
	era	11. Marital Status	12. Was Decedent Ever In I	J.S. 13			Specify Yes or No		- American Indien,	
al', or iter Examiner	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 2	t of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	rto Rican, etc.)	Specify.	k, White, etc.	
atrice	te	15. Decedent's Ed	ucation	16e. Dec	edent's Usuel (Occupetion		16b. Kind of Bu	siness/Industry	
- 9	Completed	(Specify only highest grade Elementery/Secondary (0-12)	de completed) College (1-4or 5+)	(Giv life.	e kind of work DO NOT use	ind of work done during most of wo O NOT use retired)				
	E	11	College (1-401 5+)	Supe	rvisor			Electron	nics Assembly	
d other event, t	Bec	17. Fether's Name (First, Middle, Last)				18. Mother's No	eme (First, Middle,	Maiden Surnem	θ)	
200	To B	Alfred John	Biebl			Viola	Victo	oria V	Wiseman	
th and Mente 7 is marked treumatic ev	-	19e. Informent's Neme/Reletionship (7	Type, Pnint)	19b. Mai	ling Address (Street end Number or F	Rurei Route Numb	er. City or Town	State Zin Code)	
d T		Frank J. Hormes,				prook Rd.,				
- P E &		20a. Method of Disposition	20b.	Plece of Disp	osition (Neme	of	Del All,		City or Town, Stete	
or 11		1 Burlel 2 □ Cremetion 3 □	Removel from State	cemetery, cre	emetory or other	r piece)				
tment of tant: If ite		4 □ Donetion 5 ☑ Other (Specify					7/15/98	Bel Air	r, Maryland	
Depertment of Important: If I any Injury or once.		21. Signature of Funerel Service Licen	Huck	H	oward I	Address of Facility C. McComas Lesbury Rd.			e, P.A. 21009	
		23a. Pert1. Enter the diseese, or composhock, or heart failure. List only	plications thet caused the dee	th. Do not er	nter the mode	of dying, such es cardi	ac or respiretory e	rrest,	Approximete Intervel Between	
nysician		Shook, or heart failure. East only t	one cauge on each line.						Onset end Deeth	
Medical		Immediate Cause (Finel	SEPSIS						1000	
kaminer		resulting in death)							DAYS	
	9		0	or es e conse	equence ot):				\	
ansit	盲		b. Pheumi		1				DHAT	
physiclen end s the buriel-trensit	Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or es e conse	equence of):				1	
Sicle		Ceuse (Diseese or Injury thet initieted events			1					
s the	/Medical	resulting in death) Last			1					
nding physicien end use es the buriei-trensit	Š		d						1	
6 3										
ed by the ette detached for	Physicia	Pert II. Other eignificant conditions co	entributing to death but not re-	sulting In the	underlying cau	se given in Pert I.	23b. Dld	tobecco uee con	tribute to the cause of de	
d by letac	Ph	BRAIN TUM	10				10	Yes 2□ No	3 Probably 4 Wonki	
E 2	þ	1- TOTAL TOTAL	IIC				-			
peen s should	Completed							en eutopsy med?	24b. Were eutopsy findin eveileble prior to	
9 -	ple								completion of cause of deeth?	
S C/	E						10	Yes 2 No	1 ☐ Yes 2 ☐ No	
hes Je 2		25. Wes case referred to medical				OF Disco of D	eeth (Check only o	-	10100 2010	
ate hes pege 2	0	exeminer?	Hospitel:	TER/Owter ette	-1 0 DO1	Other				
ate hes pege 2	o Be		28a. Date of Injury	ER/Outpetie		4 Nursing	Home 5 Reside			
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iter deeth. Irector: After this certificate hes n by the funeral director, pege 2	Certification: To	27. Menner of Deeth 1 Selection 2 Accident investigation 3 Suicide 6 Could not be	28e. Plece of Injury - At h	ome, ferm, s			28f. Location (City or Tox	Street end Numbe wn, Stete)	er or Rural Route Number,	
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iter deeth. Irector: After this certificate hes n by the funeral director, pege 2	edical Certification: To	27. Menner of Deeth 1 Selection 2 Accident 3 Suicide 4 Homicide 29a. Certifier	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, s	treet, factory, o	ffice	City or To	wn, Stete) ceuse(s) end me	nner es steted.	
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ter deeth. Fector: After this certificate hes n by the funeral director, pege 2	edical Certification: To	27. Menner of Deeth 1 Matural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Menner of Deeth 5 Pending investigation 6 Could not be determined	28e. Plece of Injury - At houlding, etc. (Special colors) and the best of my known ther: On the best of examinating the special colors of examinating the special colors of examinating the special colors.	nome, ferm, s	treet, factory, of	ffice the time, date end pled my opinion, deeth occ	City or Ton	wn, Stete) ceuse(s) end medete end pleca, e	nner es steted. and due to the ceuse(s)	
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hes ye 2	edical Certification: To	27. Menner of Deeth 1 Matural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 200. Signature and title at certifier 30. Neme end eddress of person who certifier	28e. Plece of Injury - At I building, etc. (Special Control of the Special Control of the S	ome, ferm, s fy) owledge, dee ation end/or in	th occurred et nvestigation, in 29c. L	ffice the time, date end pled my opinion, deeth occ	City or Ton	ceuse(s) end mei dete end pleca, e 29d. Dete signed	nner es steted. and due to the ceuse(s) if (Month, Dey, Yeer)	

Hormes, Frances M



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dev Month Yee **Physician**) ensen JULY 10, Anniece C. 2:15PM 1998 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. 8. Date of Birth Month, Day Year, 1925 Hours Min. Mar. 22, 1925 Texas If Under 1 Year Birthpiace (State or Foreign Country) Months 7. Age (In yrs. last birthday) **Funeral** Days 1 M 25 F 463-20-4407 73 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rsf', or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 316 Farm Road 21001 U.S.A. Funeral deeth 14. Race - American indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 72 hours after 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married "naturel", or 1 Ves 28 No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Convenience Stores Sales Person 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health end Mental I Important: If Item 27 is marked of any Injury or other traumatic eve Jack Cage Corrine Rucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Debbra Friedman (Daughter) 606 Northgate Road, Aberdeen, Maryland 21001 of Disposition (Name of Date 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemeter 1/22/98 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician and for use es the bunel-trensit The lew requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. thet initiated events resulting in deeth) Last Due to for as a consequence of signed by the e D.O. 23b. Did tobacce use contribute to the cause of death? auting to death but not resulting in the underlying cause given in Part I. 1E Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed is certificate hes director, pege 2: 1 Yes 1 ☐ Yes 2□ No Division of Vital Hospital or Attending Physician: 24 hours efter death. Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Inpatient 9 1 Yes 2 No After this 27. Manner of Death 1 Matural Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c, Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident Director: / 26f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier 30. Name address of person who completed gause of death (item 23a) (Type, Print) 1212 york Rd Lutherville, Md. 21093

State Registrar John C

31. Date filed (Month, Day, Year)

rice

3 1998

82. Registrar's Signature

Ik Davideor Rardall

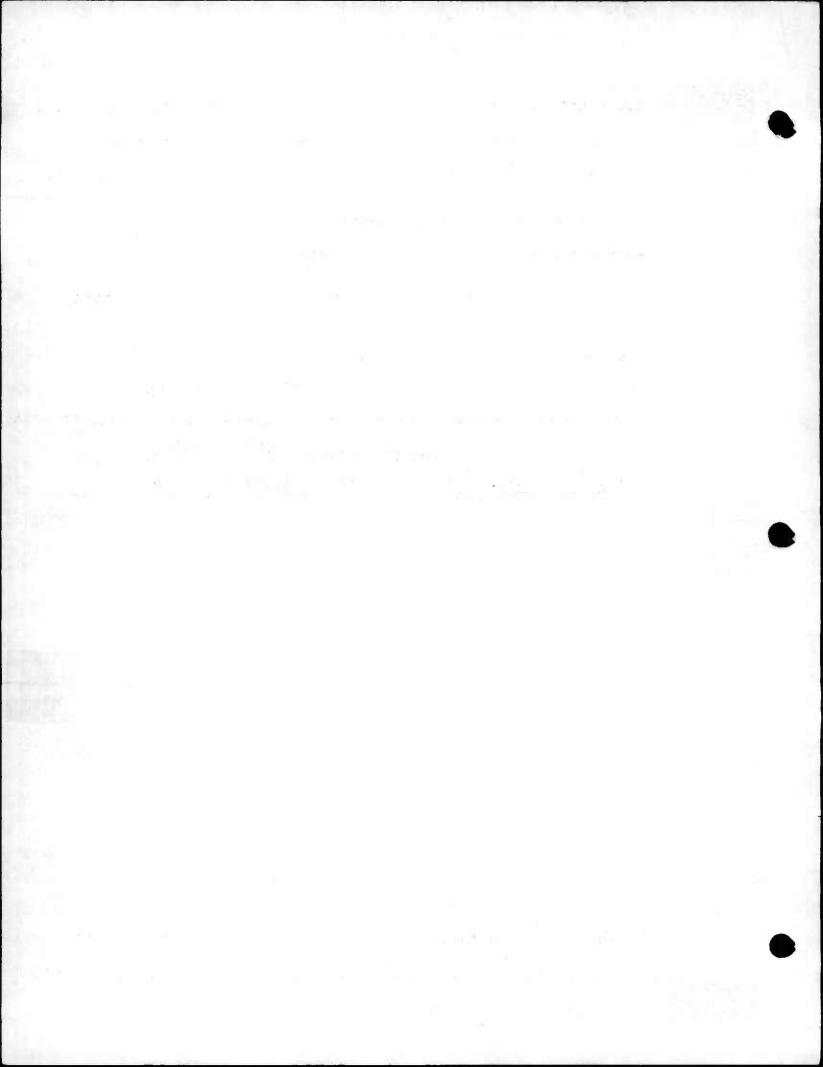
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State of Maryland / Department of Health and Mental Hygiene

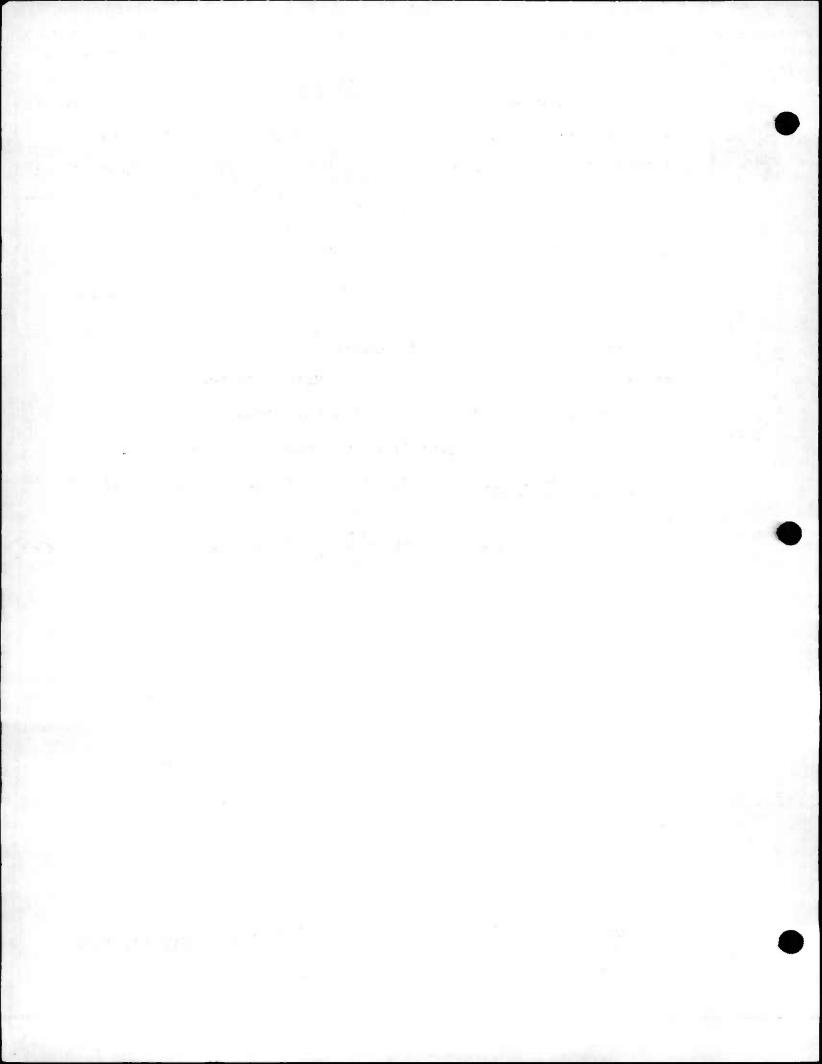
		OB G764 PER F.H. G7		30 1111	Sertificate of	Death	2. Date of Dec	Reg. No.		3. Time of Death
Physic		Gladys Winifre	*				July	Day	Yaar 1998	12:30 an
/Med Exami		4a. Facility Name (If not institution, giva				4b. City, Town, or L				12.30 an
Cxanii	iiei	Sears Manor Nu		ome		Annapo	lie	Anne		201
Funeral	Г	5. Social Sacurity Number 6. Se	x 7. Ag	e (In yrs. last birth	day) If Under 1 Year		8. Date of Birt (Month, De			ace (Stete or Foreign
Director		091-24-1612	□ M 2√2 F	91 Y	rs. Months Days	Hours Min.		1906		
P >		091-24-1612 Usual Residence of Decedant		40.00			~~~,			
h the Marylen r 28a-f show	-	10a. State 10b. County WESTCHES		10c. City, Town	or Location				10	Od. Inside City Limits
Sa-f	cto	NY Suracu	se	Cro	ton-On-Hu	ıdson				1 ☐ Yes 2 ☐ No
vith ti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Count	try?
death with the Maryland ms 23a or 28a-f show Linual be notified at	Funeral	43 Radnor Aven			105			USA		
	, and	11. Maritai Status	12. Was Decedent Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Rac Blac	e - Amarica k, White, e	
d 21215-0020 filed within 72 hours atter thyglene. ther than "natural", or its inf, tin Medical Examine	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Datas:	No	1□Yes 2√ No	Specify:		Specify	Whi	te
Maryland 21215-0020 d2 should be filed within 72 hours aft th and Mental hygiene. 7 is marked other than "natural", or traumatic event, are Modical Event traumatic event, are Modical Event	8		COMP. Televiting	160 [Decedant's Usual Occu	unation	1	16b. Kind of Bu		
15 in 72 in 72	Completed	15. Decedent's Edu (Specify only highest grad			Give kind of work done lifa. DO NOT use retire	during most of work	ing	TOD. KING OF BE	Janiessinu	ustry
d 212 filed within Hyglene. other than	E	Elementary/Secondary (0-12)	College (1-4or 5					Sel	l f	
be filed ntal Hygind other	Bec	12th grade 17. Fathar's Name (First, Middla, Last)		H(omemaker	18. Mother's Nam	e (First, Middle,			
arylan should be in marked of	To B	Eugene L. Kraf	f+			Florer	ana Dat			
shot mer	-	19a. tnformant's Name/Relationship (T)		19b. I	Malling Address (Stree	ot end Number or Rui	ral Route Number	tinger	Stata, Zip	Code)
ore, Maryla is 1 and 2 should to if Heelth and Ment item 27 is marked other traumatic of		Charles S. Koe	gel - So	n 307	7 Five Fa	rms Driv	re Ste	ovenevi	110	MD 2166
of He othe		20a. Method of Disposition		20b. Place of D	Disposition (Neme of crematory or other ple		Data	20c. Location -	City or Tov	wn, State
Baltimore, bernit. Pages 1 et Department of Hee mportant: if item; iny injury or other 2008.		1 □ Buriai 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from Stata		ption Ce	· IIIIV	30, 1	998 Syrac	1156	NV
Baltimore, M permit. Pages 1 end 2 Department of Heelth a important: if item 27 is any injury or other tra once.		21. Signature of Funeral Service Licens	ee,/o/	1	22. Name and Addr			byrac	use	141
Depa Impo		1/1/ M	491	/	Fellows,	Helfenk	pein &	Newnan	1	
		23a, Part 1. Enter the disaase, or compi	ications that caused	the death. Do no	106 Sham	rock Rd.	, Ches	ster, M	1D 2	21619 Approximate
) Physician		23a. Part1. Enter the disaase, or compl shock, or haart fallure. List only o	na causs on each iir	ne.	,		or roopilatory a.			Interval Betwaan Onset and Death
/Medical		immediate Causa (Finai	0							13 1
Examiner		disease or condition rasulting in death)			UBST	nucii	UNI			4 uni
	ē			Due to (or as a co	insequence or):				i	
58760, icete be executed physician end s the buriel-transit	edical Examiner	Sequentially list conditions	b. ————	Dua to (or as a co	nsequence of):					
C exec	Ĭ.	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or Injury that initiated events								
68760, ificete be execut g physician end es the buriel-trar	cal	Causa (Disease or Injury that initiated events rasulting in death) Last	c. Dua to (or as a consequence of):							
ng pt		rasulting in death) Last							i	
death cert death cert e ettendin	any		d						<u> </u>	
deal deal	sici	Part li. Other algnificant conditions con	ntributing to death bu	ut not rasuiting in t	he underlying cause g	iven in Part i.	23b. Did t	obacco use cor	ntribute to	the cause of death?
P.O.	Physician/N						101	Yes 2□ No	3 □ Prob	ably 100 Unknown
S, as the gened	þ	*								
Vital Records, P.O. Box 6 siden: The law requires that the death certific certificate has been signed by the ettending prector, page 2 should be detached for use as	9						24a. Was	an autopsy med?	24b. We	re autopsy findings ilabia prior to
law re	Completed						pono		con	npletion of cause leath?
The la	E						101	res 2 No	10	Yes 2 No
Vital Rec	0	25. Was case referred to medical				26. Place of Deat	h /Check only o			100
- 5 0 D	To B	examiner?	lospitai:	nt 2 ER/Outp	atient 3 DOA	4		dence 8 Oth	ar (Snacify	1
Division of or Attending Physical death. Director: After this in by the funeral di		27. Manner of Death	28a. Date of injur	y 28b. Tin				now injury occurr		,
Vision Attending r death. ector: After by the fune	atio	1 Naturai 5 ☐ Pending investigation	28a. Date of injury (Month, Dey Year) 28b. Time of injury 28c. Injury at Work? 1							
VIS Pr de ecto by th	tific	3 Sulcide 6 Could not be detarmined	28e. Piaca of inju	ury - At home, fam	n, street, factory, office		28f. Location (S City or Ton	Street end Numb	er or Rurel	Route Number,
od party of or	Certification:	Tiomoda	building, etc	. (Зресну)			City or You	m, Stete)		
Division of To the Hospital or Attending Phy Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifying Physical Examination (Check only 2 Medical Examination)	sician: To the best of	of my knowledga, o	death occurred at the t	ime, date and place,	and dua to tha	cause(s) and ma	nner as sta	ated.
he H in 24 he Fi	edicai	one) 2 Medical Exami	and manner sta	axamination and/elted.	or Investigation, in my	opinion, death occur	red at the time, o	date and place, a	and due to	the cause(s)
To the within 2 To the comple	Σ	29b. Signatura and title of certifier	0			se number		29d. Date signad	(Month, E	Dey, Year)
		John St	rame			27838	-	7/2	20	18
50 00		30. Name and address of person who co	empleted causa of de	eath (Item 23a) (T	ype, Print)					_
		JOHN SHAVE	ins 5	18 cm	ype, Print) Pandale	אם דוכמו	UAS	LINIT	MCL	17,00
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 11, **Physician** Edna M. Keeney 1998 6:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1612 Main St., Apt. 1 Cardiff Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/2/07 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2CH 205-16-5308 91 Director Pennsylvania Usuel Residence of Decedent the Maryland pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Harford Cardiff YEYes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1612 Main St., Apt. 21060 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ Mo Specify: þ Specify: White XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred A. Cooper Martha Guyton 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Keeney Jr., - son PO Box 186, Ft. Loudon, PA 17224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ™urlal 2 ☐ Cremation 3 ☐ Removal from State Slate Ridge Cemetery 7/15/98 Delta, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Harkins F.H.Inc., PO Box 485, Delta, PA 17314 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Enter the disease, or compositions that caused tree, or heart tailure. List only one cause on each line Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or es a consequença of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. To the Hospital or Attendiwithin 24 hours effer death.
To the Funerei Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

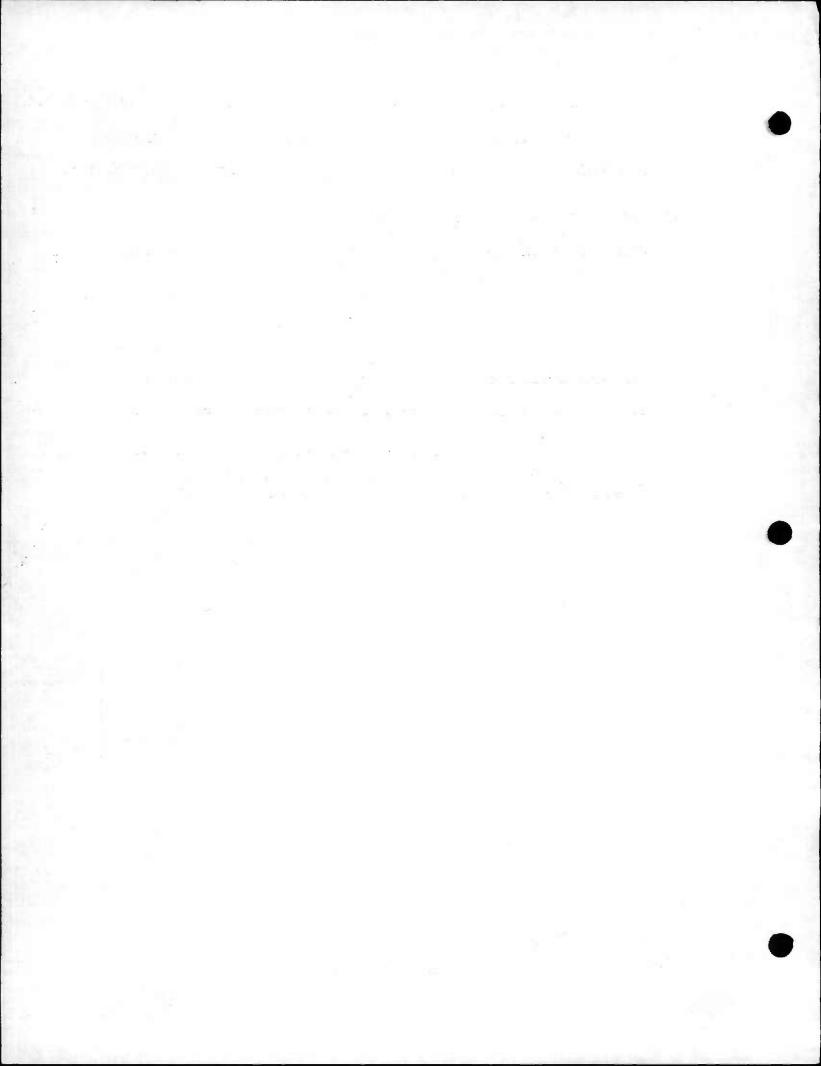
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature a a of certifier 29c. License number 29d. Date signed (Month, Day, Year) Trendin July 13, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. 2112 Bel V.S. Nair, M,D. Air Road, Fallston, MD 31. Date filed (Month, gay 998) State Registrar



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State of Maryland	/ Department of Health a	nd Mental Hygiene	98	232	11
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						Certificat	e of	Death		Re	g. No.		tina (
			1. Decedent's Nema (First, Middle, L	ast)		T ST				2. Date of Deeth	1	Vani	3. Time					
	Physicia /Medic		ALICE MARII	E KRASS						July	12 ^{ey} 1	998	5:00	A.M.				
	Exami		4e. Fecility Name (If not Institution, g							ocation of Death	4c. County	of Deeth						
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	Funeral Director		5. Sociel Security Number 6. 218–72–3353 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 ☑ F	a (In yrs. lest bir 90	Yrs. If Under Months	1 Year Deys		24 Hrs. Min.	8. Dete of Birth (Month, Day, Mar. 31	, 1908	9. Birthp Cour Mary	piece (Stete http: Land	or Foreign				
	in all yield A 12.13-0020 Id should be filed within 72 hours after death with the Manyland If and Mentel Hyglene. If is marked ofther than "natural", or items 23s or 2ss-f show traumatic event, the Medical Exaciting rives be notified at		10e. Stete 10b. County		10c. City, Tow	n or Location	_					1	Od. inside (City Limits				
		Director	Maryland Har	ford	ord Aberdeen								1 □ Ye	s 20XNo				
			1202 Carsins	Run Road	Run Road 2			001			10g. Citizen of Whet Country? U.S.A.							
020		by Funeral	11. Merital Status 1 Nevar Married 2 Married 3XXWidowed 4 Divorced	12. Was Dacedant I Armed Forces? 1 Yes 2 N If Yes, Give Yaar or Datas:	="	.S. 13. Was Decedent of Hif Yas, specify Cub 1 ☐ Yas 2 No			gin? (Sp n, Puarto	ecify Yes or No- Rican, etc.)		k, White,	en indien, etc. nite					
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	d 2 sh th and 7 is rr traum		19e. Informent's Neme/Reletionship John J. Krass,							el Routa Numbar, City or Town, State, 2 Aberdeen, Maryl								
baitimore,	permit. Pages 1 en Department of Heeli important: If item 2' any injury or other once.		20e. Method of Disposition 1 XBuriai 2 Cremetion 3 4 Donetion 5 Other (Spec		cameter	Disposition (Narry, cremetory or o	ther ple	eran C	em. 7	Deta 2 / 15/98	20c. Location -			ınd				
Dall	Departri Departri Importa any inje		21. Signature of Fugleral Service Lice	B Car	=0					ral Home 21001-								
Æ.	Physician /Medical		23a. Part I. Errier the disease, or our shock, or heert fellure. List onli immediate Cause (Final disease or condition	OB STRUC	DUE IN	not entar tha mod	e of dy	ing, such es					Approximatintervei Be Onset end	tween Deeth				
Ш	Examiner	iner	resulting in deeth)	ө		consequence of):												
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נ	sw requi	pieted by			Completed b									24e. Wes er perform		ev	ere autopsy eilable prior mpletion of deeth?	to
	The ate h	Son								1 □ Ye	s 25 No	1[Yes 2	□ No				
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	Attending P r death. sctor: After I by the funera	Certification:	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not	(Month, Dey						28d. Describe how injury occurred								
	urs after or ral Direct lled in by	- 1	4 Homicide determined	building, etc	. (Specify)					28f. Location (Str City or Town,	, Stete)			m <i>ber,</i>				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	ledical	one) 2 Medicai Exa	hysician: To the best of miner: On the basis of end menner ste	exeminetion end	Vor investigation,	in my	oplnion, dee	d pieca, th occurr	end due to the ca ed et the time, de	use(s) end me ite end piece, e	nner es s and due to	teted. the ceuse	(s)				
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	6		30. Name and address of person who	125/ een ins	MESIS	E PKNY	547	r A	Ber	ا د د د د د د د د د د د د د د د د د د د		-						
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	#				07 01	3//							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #10A-C, E-G, PER IF. G762 8-3-98 WR. 1. Decedent's Name (First, Middle, Last) 2. Dafe of Deeth 3. Time of Death **Physician** JOHN FRANKLIN LUTHY JR. 16 1998 1:25 pm July. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Dorchester 4432 Maple Dam Road Cambridge If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months 215-26-4914 69 Director May 31 1929 Mary land Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "neture!, or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be not find another. 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Cambridge 1 Yes ZONO Director FLORIDA CHARLOTTECET CAPE HAZE 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. U.S.A. 75 SPYGLASS 33946 by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) farming self emp. businessman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Bertha Pauline John Frederick Martha Schnoor Luthy 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 4432 Maple Dam Rd. Cambridge MD 21613 Mrs. Marilyn H. Luthy-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Bucktown Churchyard 7/19/1998 Cambridge Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Facility
Thomas Funeral Home PA 21. Signature of Funeral Service Licenses 700 Locust St. Cambridge MD 21613 23a Part Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. **Physician** Normall cell bing lancer. Immediate Ceuse (Finel disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner g physician end es the buriel-transit the Hospital or Attending Physicisn: The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lesf Due to (or as e consequence of): Records, P.O. Box 68760. Due to (or es e consequença of): ettending p Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ 468 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

þ Completed

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No

5. Wes case referred to medical exeminer? 1 Yes 2 No		26. Place of Death (Check only one)								
		Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□	DOA Other: 4 Nursing	Home 5 ■ Residence 6 □ Other (Specify)				
7. Manner of Deat 1 Naturel 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work?	28d. Describe how injury occurred				
3 ☐ Suicide 4 ☐ Homlcide	6 Could not be determined		ome, ferm, stree	et, fact	ory, office	281. Location (Street end Number or Rural Route Number City or Town, State)				
29a. Certifier (Check only one)	1 CertifyIng Ph 2 Medical Exam	yelclan: To the best of my kno niner: On the basis of exemine end menner steted.	owledge, death o etion end/or inve	ccurre	ed at the time, date and pled on, in my opinion, deeth occ	ce, end due to the ceuse(s) and menner es steted. curred et the time, date end place, end due to the ceuse(s)				

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29b. Signetur	and title of certifier Sully

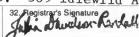
29c. License number

29d. Date signed (Month, Dey, Year)

30. Neme and address of parson who completed cause of deeth (Item 23e) (Type, Print)

David H. Smith, M.D. 509 Idlewild Ave. Easton MD 21601

31. Dete filed (Month, Dey, Year)



Division of Vital

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To the Hospital or Attending within 24 hours efter death. To the Funerel Director: Aft completely filled in by the fur

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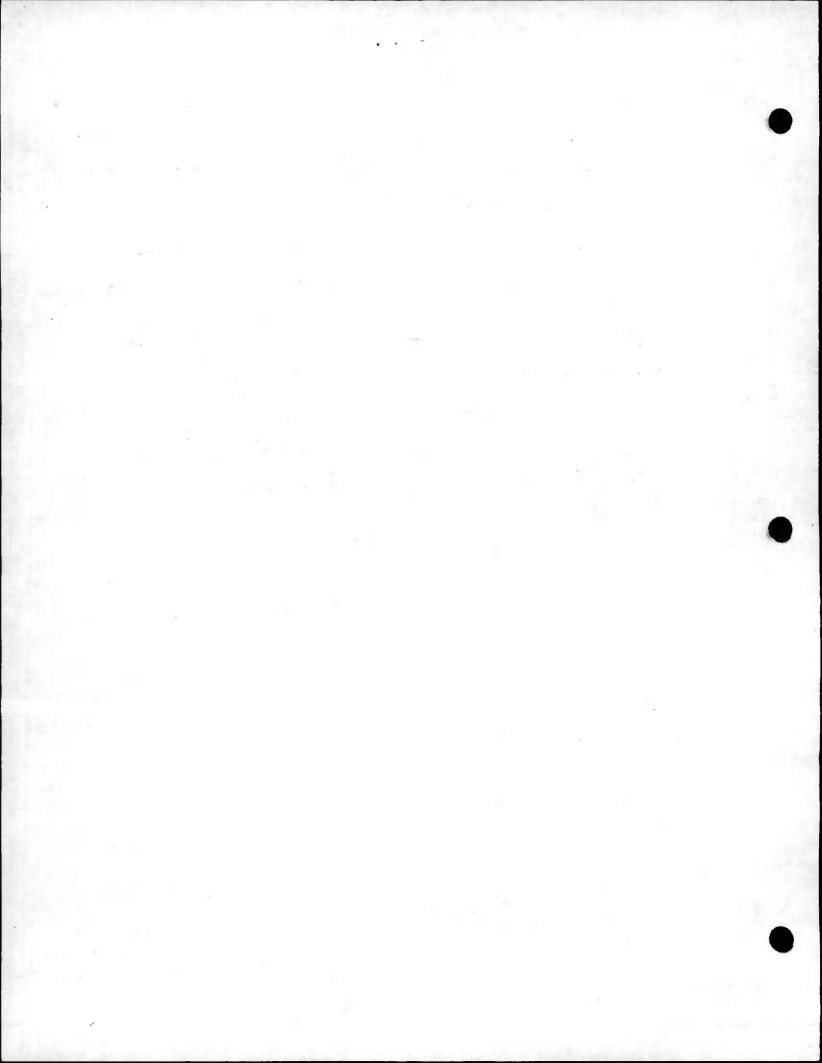
State Registrar Leavent Till the County

4 200

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 01:45 Jane P. Martin July 10,1998 /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 4, 1915 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2XX Months 83 215-07-9023 Director Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Queen Anne's Chester 1 ☐ Yes 2 No Director 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 238 1350 Calvert Road 21619 U.S.A. 'natural', or items 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 22No
If Yes, Give
Yeer or Detes: filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 Specify: White X Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Self 11 permit. Pages 1 and 2 should be fin.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other treumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Dallas Holland Hearn Lula Byrd Patrick 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra George (Daughter) 1320 Queen Anne Dr., Chester, Md. 21619 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition July 13, X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetign 5 Other (Specify) Kingsley Church Cemetery Chester, Md. 22 Name end Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
106 Shamrock Rd., Chester, Md. 21619 21. Signeture of Funeral Service Licensee 23a. Part 1. Enter the disbase, or complications that caused the dwell shock, or heer lailyire. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical 00 Examiner Due to (or es e consequence of): noteusion sician and burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician the buriel P.O. Box 68760. by Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown vena/ Records, 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and tiple of dertiller 29c. License number 29d. Date signed (Month, Day, Year) 7/10/98 MED. Hom 23a) (Typo, Print), Anne Arundel Medical Center Annapolis, Md 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hal 15 MD. her/es 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State June wardson Handell JUL 1 4 1998 Registrar



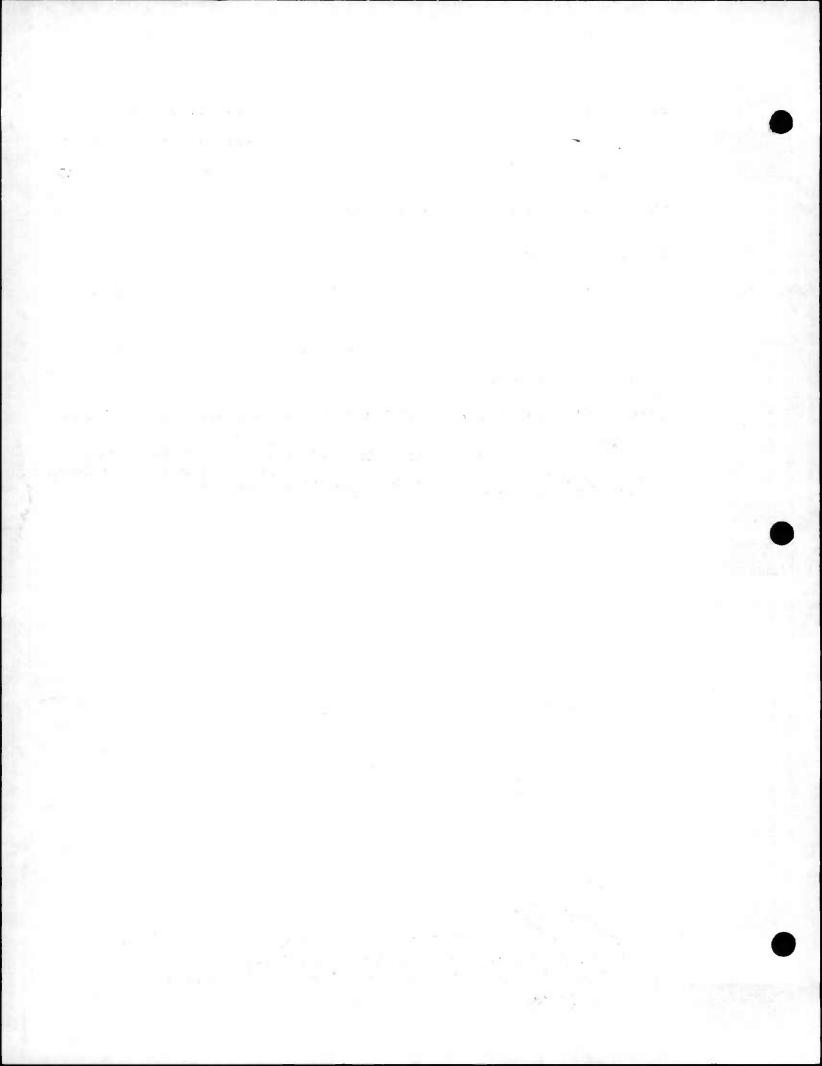
State of Maryland / Department of Health and Mental Hygiene

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Н	Formand	-		Sax 7.	Age (In yrs. i	lest hirthday)	If Under 1		If Under 24 Hrs.			Talb	9. B <u>i</u> rthplec	o (Stato d	r Eomian
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	land		10a. State 10b. County	-	10c. City	y, Town or Lo	ocation						10d.	Inside Ci	ity Limits
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	r 28	Director	10e. Street end Number		De.	IVII CIIG	10f. Zip C	Code			10g. Ci	itizen of V	Whet Country	?	
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	taal m 2		20a. Method of Disposition	ssick Wi		P.O. lece of Dispo			St. Mich	aels, Ma	-		21663 City or Town	Ctata	
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-	S. 2015	1	23a. Pert1. Enter the diseese, or conshock, or heart tailure. List only	mplications thet caus	ed the deeth	n. Do not ent	er the mode	alb of dvin	ot St. S	t. Micha	els	, Md	2166	3 poroximet	A
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7	/Medical		Immediate Ceuse (Finel diseese or condition	Till	MAA	IARX	1	is	COSIS				1/	- 44	6
	Examiner		resulting in death)	e. / O C		r es e conseq							12	MIC	0
-	p Æ	ner.					,						2		
	death cartificate be axecuted a ettanding physician and of for use es the bunal-trensit	Examiner	Sequentially list conditions,	b. ————	Due to (or	r es e conseq	juence of):								
68760,	oe axi		Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury												
87	hysiq the t	Medical	thet initieted events resulting in deeth) Lest	G	Due to (or	es e conseq	uence of):								
×	artific ding p	Me		l d											
Bo	ettan for us	Physician/													
o	D a D	ysic	Part II. Other eignificent conditions	contributing to death	but not resu	ilting In the ur	nderlying cau	use give	en in Pert I.	23b. Dld te	bacco	uee cor	ntribute to th	e cause o	of death?
P.0	that tha led by th detache									101	'08 2	2□ No	3 Probab	ly 4□	Unknown
ds	as De d	d by								24a. Was	-		24b. Were	autoney f	indinae
Vital Records,		Completed								perfor	med?	psy	evelle	ble prior to lation of c	0
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5		To B	25. Wes cese referred to medicel axeminer? 1 ☐ Yes 2 ∑ No	Hospital:		ED/O		Othe	26. Plece of Dea				=li=avi		
o	r this		27. Manner of Deeth	1 ☐ Inpa	njury	ER/Outpatien 28b. Time of			4 LI Nursing H	ome 5 Resid					
lon	th. : Aftar a funa	tion	1 XNaturel 5 ☐ Pending 2 ☐ Accident Investigation	(Month, E	Dey Year)	Injury	М	c. Injun Work	(? Yes 2 □ No						
Division	or Attanding effer daath. Director: Affai I in by tha funa	Certification:	3 Suicide 6 Could not	be 28e. Plece of I	njury - At ho	me, farm, str	eet, factory, o	office		28f. Location (S	treet e	nd Numb	er or Rural R	oute Num	ber,
ā	s effer i Dire	Sert	4 Homicide	building,	atc. (Specify	")				City or Tow	n, Stel	e)			
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affar completely filled in by the funer	edicai (29a. Certifier 1X Certifying P	ng Phyelctan: To the best of my knowledge, death occurred at the time, date and place, an					end due to the c red et the time, c	euse(s lete en	end me d plece, e	nner es stete and due to the	d. e cause(s)	
	ro th vithin romp	Me	29b. Signature end title of certifis 29c. License number 29d. Date signed (Mon							(Month, De)	y, Year)				
	- > - 0		11 toth	em 1	M		77	1/2	350			7/1	< 19	8	
		ŀ	30. Name and address of person who	completed cause of	death (Item	23e) (Type	Print)	-0.				11	-110	,	
			William S. B					+ 0.	+ 04 7/1	obcol-	B.77 -	1	- 1 010	00	
	Sta	te	31. Dete filed (Month, Day, Year)	32. Regis	trar's Signat	ure	14100	LD	t. St. M	chaers,	IVIA	rytai	nd_216	63	
	Registr		1111 16	1000	Willia No.	:1 7	2								



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_					-	Certificate of			Reg. No.	5 2	3218
	Physici	an	1. Decedent's Neme (First, Middle, La	st)				2. Date of De Month	eth Dey	Yeer	3. Time of Deeth
	/Medi		Marie Helen					July	16,1998		9AM
	Examir	ner	4e. Fecility Neme (If not institution, giv	Commence of the			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
			407 Victoria W				Stevens				
	Funeral		5. Social Sacurity Number 6. S	ex 7. Age □M 2DXF	(In yrs. last birtl	Months Dev		8. Dete of Bird (Month, De	th y, Year)	9. Birthpie Country	ce (Stete or Foreign
	Director		212-36-1898 Usuel Residence of Decedent		88	rs.		June 9			MD
	and w		10e. Stete 10b. County		10c. City, Town	or Location				100	d. Inside City Limits
	Mary	ō	MD Queen	Anne's	Steve	nsville					1 ☐ Yes 2 ☐ No
	fier deeth with the Marylar fema 23a or 28a-1 show incr must be notified at	Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizan of V	What Countr	v?
	3a o	<u>-</u>	407 Victoria W	lav		2166					, .
	ma 2	era	11. Maritei Stetus	12. Was Decedent E	ver in U,S.		f Hispanic Origin? (Sp Johan, Mexican, Puarto	ecify Yas or No		S.A. e - American	n Indien,
0	r ite	Ē	1 Nevar Married 2 Merried	Armed Forces? 1 Yes XXN If Yes, Give	0			Rican, etc.)	Blac	ck, White, et	c.
Maryland 21215-0020	al', o	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Detas:		1 ☐ Yes 2 ☐ No	o Specify:		Specify	Whit	e
2-0	filed within 72 hours efter deeth with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-f show int, the Medical Examiner must be northed at	Completed	15. Decedant's Ed (Specify only highest gra	fucation	16a.	Decedent's Usual Occi Giva kind of work don life. DO NOT use ratir	upetion	in a	16b. Kind of Bi	usiness/Indu	stry
2	within ene. then "	g	Elementery/Secondary (0-12)	Coilege (1-4or 54	-)	life. DO NOT use ratio	red)	nig .			
7	Hygien ther th	5	12			Homema	ker		Se	lf	
nd		Be	17. Fathar's Nema (First, Middle, Last)				18. Mother's Nem		Meiden Sumen	ne)	
2	should be and Mentel marked o	P	William Sch				UNK	NOWN			
<u>a</u>			19e. Informent's Neme/Reletionship (Melling Address (Stree					,
d)	leeith m 27		James A. O'Rei	IIy/Husb							
Ö	Pages I nent of H ant: If Ite		20e. Method of Disposition 1 ☐ Buriel 2XCCremetion 3 ☐	Removel from State	20b. Pleca of cematery	Disposition (Neme of , crametory or other p	lece) July	17, 1	20c. Location - 998	City or Tow	n, Stete
	tmen tant: jury		4 ☐ Donetion 5 ☐ Other (Specifi	C1.	esapea	ke Crema	tion Cen	ter	Steven	svill	le. MD
Baltimore,	permit. Pages 1 and 2 Department of Heeith Important: If Item 27 It any Injury or other tra		21. Signature of Funeral Service Lices	***************************************		22. Nama and Add	rass of Facility Fe] Home, P. A	llows,	Helfenl	ein&	Newnam
	20240		Amy TIVI	cheeu	1	Chester	MD 216	1. 106	Shamro	ock R	d.
			23a. Part . Enter the disease, or comshook, or heart failure. Listionly	plications that caused to	e deeth. Do no	ot enter the mode of d	ying, such es cardiec	or respiretory e	rest,	A	Approximete ntervei Between
V	Physician										Onsat and Deeth
	/Medical Examiner		Immediete Ceuse (Finel diseese or condition	hu	Itishste	m Fail	lure				45
	LAGITITIE		resulting in daath)	C	ue to (or es e c	onsequence of):					
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	end end -tran	хап	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying	D	ue to (or es e co						
9	cian burie	E	cause. Enter Underlying Ceuse (Disease or Injury thet initiated events	c	Malmit	nto					
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л. О.	the d	Physician/M	Part ii. Other significant conditions of				givan In Pert I.	23b. Dld 1	obacco use co	ntribute to t	he cause of death?
	that the delay		Congetin	tear	t fa	Ilme		10	Yes 2□ No	3 Proba	bly 4 d Unknow
Hecords,	requires that the death cer ween signed by the ettendir hould be detached for use	d by	0					04-111-		Odb Wass	
Ö	v require been si should	Completed							an autopsy med?	avail	a autopsy findings abla prior to pietion of causa
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	cate							101	res 2 No	10	Yes 2□ No
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DIVISION OF VITAL	Ing F	Certification:	27. Menner of Deeth 1 ☑Naturei 5 ☐ Pending	28e. Dete of Injury (Month, Dey		ury W	ork?	28d. Describe h	now Injury occur	ed	
2	tor:	cat	2 Accident investigation 3 Suicide 6 Could not be				☐ Yes 2 ☐ No				
\geq	or Al	뒫	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, fen (Specify)	n, street, fectory, office	9	28f. Location (S City or Tow	Street and Numb vn, State)	er or Hural F	Route Number,
-1	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	-total W. W				To de proposition de la constantina de		01230 V-S2	
	Hos 24 ho Fun stely	edlcai	(Check only one)	sician: To the best of iner: On the basis of e	xaminetion end	death occurred et the for investigation, in my	time, date and plece, opinion, deeth occurr	and due to the ded et the ded et the time, de	ceuse(s) end <i>me</i> dete end placa, i	nner es stet and due to th	ed. he cause(s)
	ithin of the	Mec	29b. Signature and title of pertitier	and Manner state	su.		nse number		29d. Date signe		
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)		-	10 Harris M. J. of 12-	0000	.00		7.1004		7/1	0170)
			30. Name and address of person who	be to especial designation of designation of designation of the design	th Med 300	yee, Print	Judy	211	100		
	Sta		31. Dete filed (Month, Day, Year)	32. Registra	s Signature	cher PAI	112 100	1.410	YY		
		IC	IIII 0 1 1	000	. /	- Randell					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** JULY 17 1998 ROBERT BRUCE PATTERSON 11:55 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Yrs. Director 481-26-4337 70 FEB 26 1928 IOWA Usuet Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygians. Important: If Item 27 is marked other than "natural; or items 23a or 28a-1 show any Injury or other traumatic event, the Mexical Examples mail to notified and injury or other traumatic event, the Mexical Examples mail to notified and injury or other traumatic event, the Mexical Examples mail to notified and injury or other traumatic event, the Mexical Examples mail to a notified and injury or other traumatic event, the Mexical Examples of the proof 1 ☐ Yes 2 No Directo Maryland Prince George's Fort Washington 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 1204 Van Buren Drive 20744 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, atc. 11. Maritel Status 1 ☐ Never Merried 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Etementary/Secondery (0-12) College (1-4or 5+) US Government Scientist 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Nema (First, Middle, Last) Be Robert B. Patterson 2 Verna Marget Patterson 19a. informent's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Laurette C. Patterson (wife) 1204 Van Buren Drive Ft Washington, MD 20744 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) 7-18-98 Metropolitan Crematory Alexandria, VA 21. Signatur erel Service Licensee 22. Neme end Address of Fecility M00173 J.H. Eberwein Mortuary Ew 4433 White Pls La White Pls., MD 20695 Enter the disease, or complications that caused the deeth. Do not enter, or heart feilura. List only one ceuse on each line. Approximeta tntervet Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner ettending physician end for use es the bunel-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Box 68760. Due to (or es consequence of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings eveilabla prior to complation of cause of deeth? Completed 24e. Wes en eutopsy cate hes r this certificate h 2 TLAN 1 □ Yes 2 □ No 1 TYes Division of Vital if or Attending Physician: after death. B 25. Wes casa refarred to madical 26. Pleca of Deeth (Check only one) exeminar? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpetient 3D DOA After this funeral d 28c. Injury et Work? Data of injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred Certification: 27. Manner of Deeth 5 Panding investigation 1 Naturel i Director: A 1 Yes 2 No 2 Accident 6 Could not be datarminad 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospitai 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Hadtcal Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated. edicai 29a, Certifier To the 29d. Date signed (Mpnth, Day, Year) 29b. Sin 29c. License number 31. Deta filed (Month, Day, Year) State JUL 2 0 1998 Durcher Randall

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 1998 Edwin Clarence Ross /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Harford Mariner Health of Bel Air Bel Air If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Funeral Months Hours Days 1 M 2 □ F 82 Vrs 218-03-8518 Director Sept. 7,1915 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiern 27 is marked other than "naturel" or items 23e or 28e-f show any injury or other traumetic event, its Medical Evantment be notified as 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 250 No Aberdeen Director Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21001 Funeral 3739 Aldino Road Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 1 Yes 20 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 White 1 Yes 3€ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment Operator State Highway 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Mantie Laura Cornett Robert Lee Ross 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3739 Aldino RD, Aberdeen, MD 21001 Eula Mae Ross/Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens7-14-98 Aldino, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 131/ COKESPUTY ROAD, Abing death, it complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burlal-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): The law requires that the death certificate be Physician/Medicai Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 8 3 Probably 4 Unknown signed by þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy page 2 this certificate 1 Yes Be 25. Was cese referred to medical examiner? 28. Place of Deeth (Check only one) Other: 1 Yes 2 No P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Marmer of Death 28b. Time of 28d. Describe how injury occurred Certification: Attor Division 5 Pending investigation Natural Injury 1 ☐ Yes 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my unowiedge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of summetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the c 29a. Certifie Medical netion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner sta å 29b. Signatur 29c. License number 29d. Date signed (Month, Dev. Year) 0

State Registrar

1998

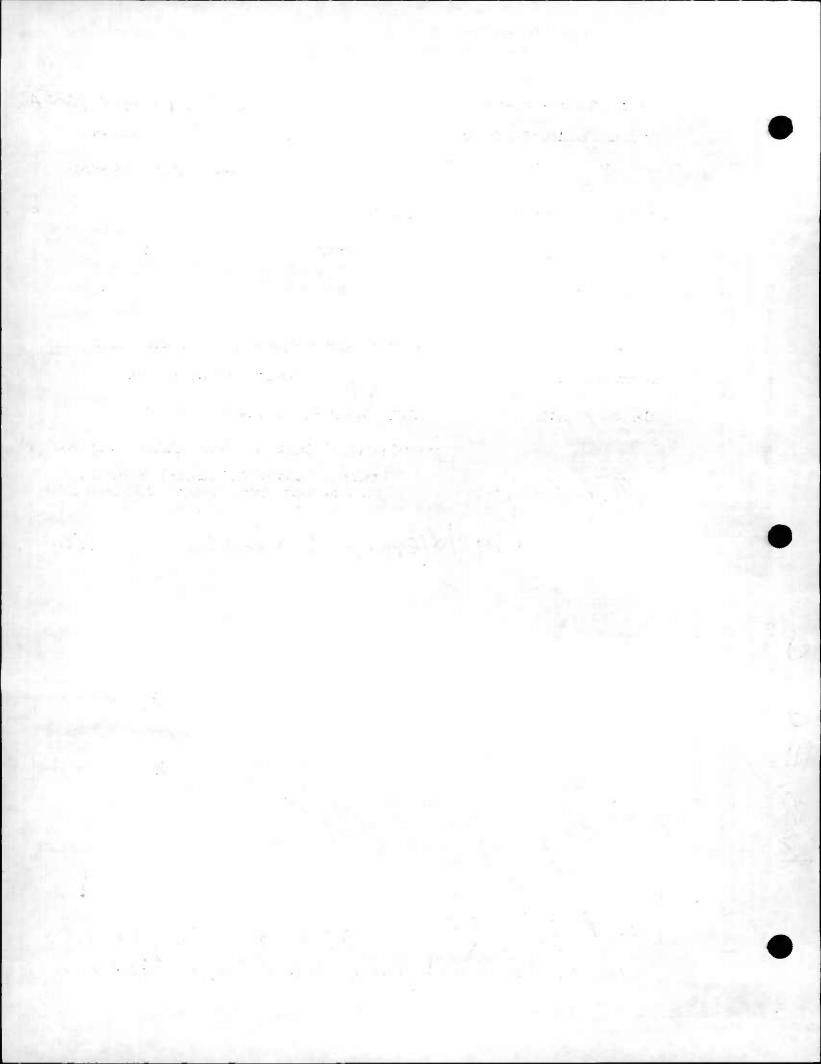
30. Name and address of person

31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

0

no completed cause of death (Item, 23a) (Type, Print) 8,6.10



ELLIS

RHINEHART

State of Maryland / Department of Health and Mental Hygiene

Certificate of L

	2. Dete of Deeth				3.	Tim	a of	
Peath	Reg. No.	2	U	Eng	U	4	4	
saili anu	wellal Hygiene	0	8	9	0	9	2	

Physician
/Medical
Examiner

Ellis Newton Rhinehart 4a Fecility Nema (If not institution, give street end number)

Month JULY 4b. City. Town, or Location of Deeth 3. Tima of Death 3:24P.M.

10d. Inside City Limits

1 X Yas 2 □ No

Funeral

5. Social Sacurity Number 6. Sex 150 M 2□ F 225-01-6279

RT.7 & OLD ELK NECK ROAD

1. Decedent's Name (First, Middle, Last)

ELKTON If Under 1 Year | If Under 24 Hrs. Months Deys Hours

8. Dete of Birth 9. Birthplece (Stete (Month, Dey, Year))
Sept. 13, 1915 Virginia 9. Birthplece (Stete or Foreign

12.

Director

Item 27 is marked other than "natural", or items 23e or 28s-f show other traumetic event, the Medical Examinar insulate notified at

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Physician /Medical

Examiner

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certificate

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After

The law requires that the death certificate be axecuted

Records, P.O. Box 68760,

Division of Vital

Hospital or Attending Physician:

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Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health end Mantal Hygiene. If them 27 is marked other than "natural", or its

Maryland 21215-0020

Baltimore,

the Maryland

Usual Residence of Decedent 10a State 10b. County Director Maryland 539 Law Street Funeral

Harford

10c. City, Town or Location Aberdeen

Yrs

10e. Street end Number

10f. Zip Code 21001

7. Age (In yrs. lest birthday)

82

10g. Citizen of What Country? U.S.A.

11. Maritel Status

1 ☐ Never Married 2 ☑ Married 3 Widowed 4 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Giva Year or Dates:

 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 X No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

Year

1998

4c. County of Deeth

15. Decedant's Education (Specify only highest grada completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) Policeman

22. Name end Address of Fecility

16b Kind of Business/Industry Police Dept.

17. Fether's Neme (First, Middle, Last)

Jacob Rhinehart

18. Mother's Name (First, Middle, Malden Sumeme)

Mary Laverne Layman

19a. Informent's Name/Ralationship (Type, Print)

19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Coda)

Ronald E. Rhinehart (Son)

20b. Place of Disposition (Neme of cemetery, crematory or other place)

5 Rockdale Avenue, Churchville, Maryland 21028 20c. Location - City or Town, State

20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify)

Harford Memorial Gardens 7/18/98 Aberdeen, Maryland

21. Signature of Fusiefal Service Licenses

23a. Part1. Enter the disease, or complications that caused the caath. Do not antar the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line

Tarring-Cargo Funeral Home, P.A Aberdeen, Maryland 21001-3399

Immediata Causa (Final disease or condition rasulting in daath)

humple Disjues Dua to (or as a consequence of)

Sequantially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseasa or Injury that initiated evants rasulting in death) Last

Due to (or es e consequence of).

Due to (or es e consequence of)

Part II. Other algolificent conditions contributing to death but not resulting in the underlying ceusa given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy

24b. Wera eutopsy findings aveileble prior to completion of cause of death?

Approximate Interval Between Onset end Deeth

1 Yes 2 No

26. Plece of Death (Check only ona)

1 BYes 2□ No

25. Wes cesa rafarrad to medical NØ Yes 2□ No

27. Manner of Death 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Dete of Injury (Month, Dey Year) 28b. Time of Injury 1298 1522PM

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Rasidance 6 Rothar (Spacify) SCENE 28d. Describe how injury occurred DRIVENOF CARTHCOLLISION WITH PICK

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) RTZ toud ELLL VECKLOS CECILLO MO

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledga, deeth occurred et the time, dete end plece, end dua to tha ceusa(s) end mannar as stated.

2 XMedical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred et tha time, data end place, end dua to the cause(s) end menner stated.

29b. Signature and title of certific Winds

29c. License number O.C.M.E. 29d. Date signed (Month, Dev. Year) JULY 13,1998

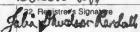
30. Name and eddless of person who completed ceuse of deeth (Item 23e) (Type, Print)

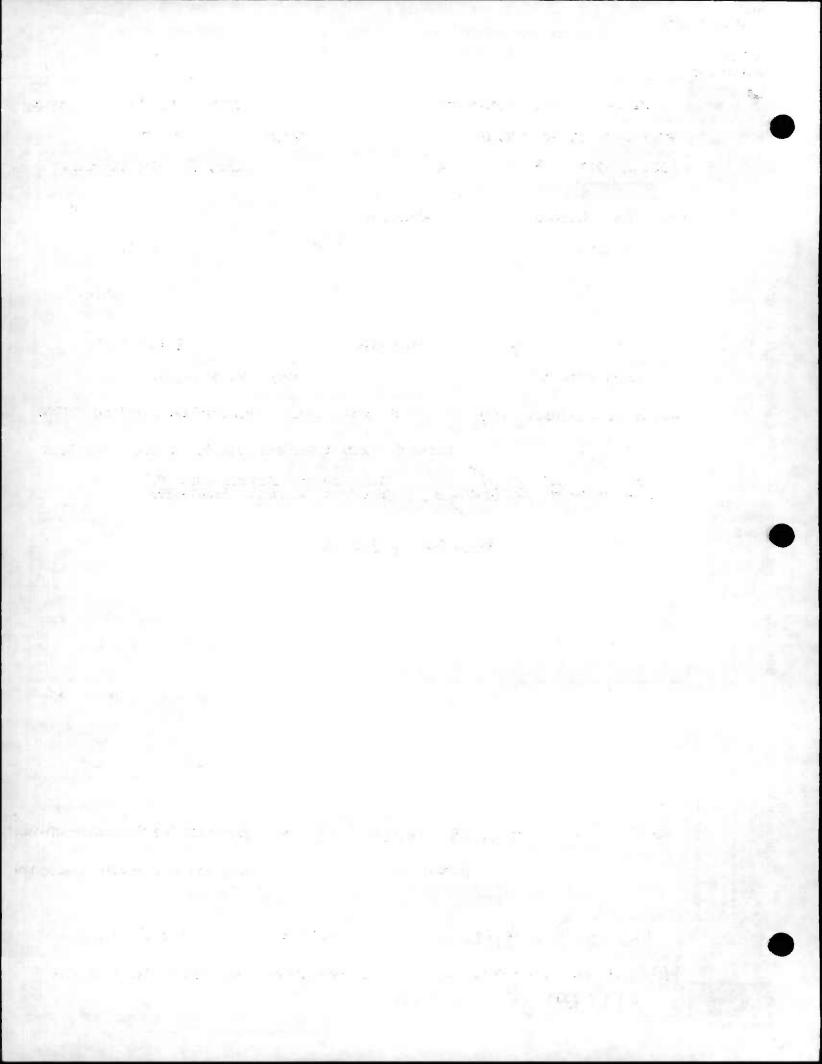
MAMAD MAD 31. Date filed (Month, Day, Year)
JUL 17 199

D. KOREW UM

111 Penn Street, Baltimore, Maryland 21201

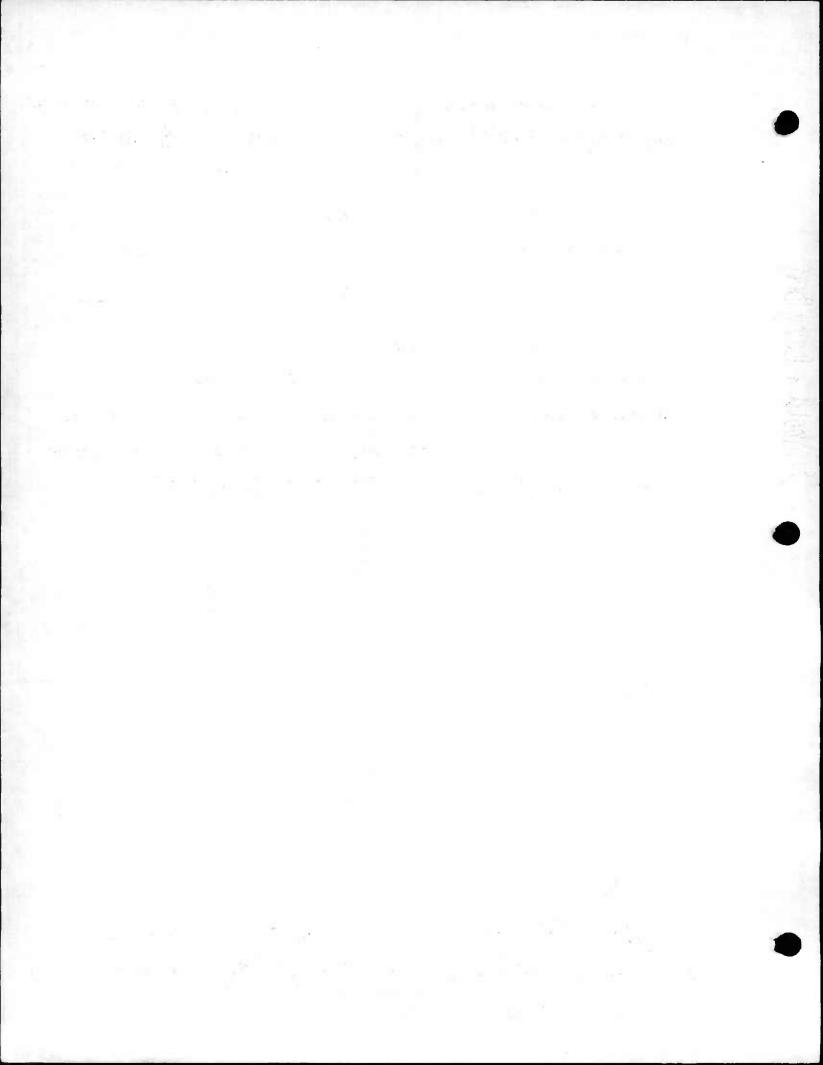
Registrar





State of Maryland / Department of Health and Mental Hygiene

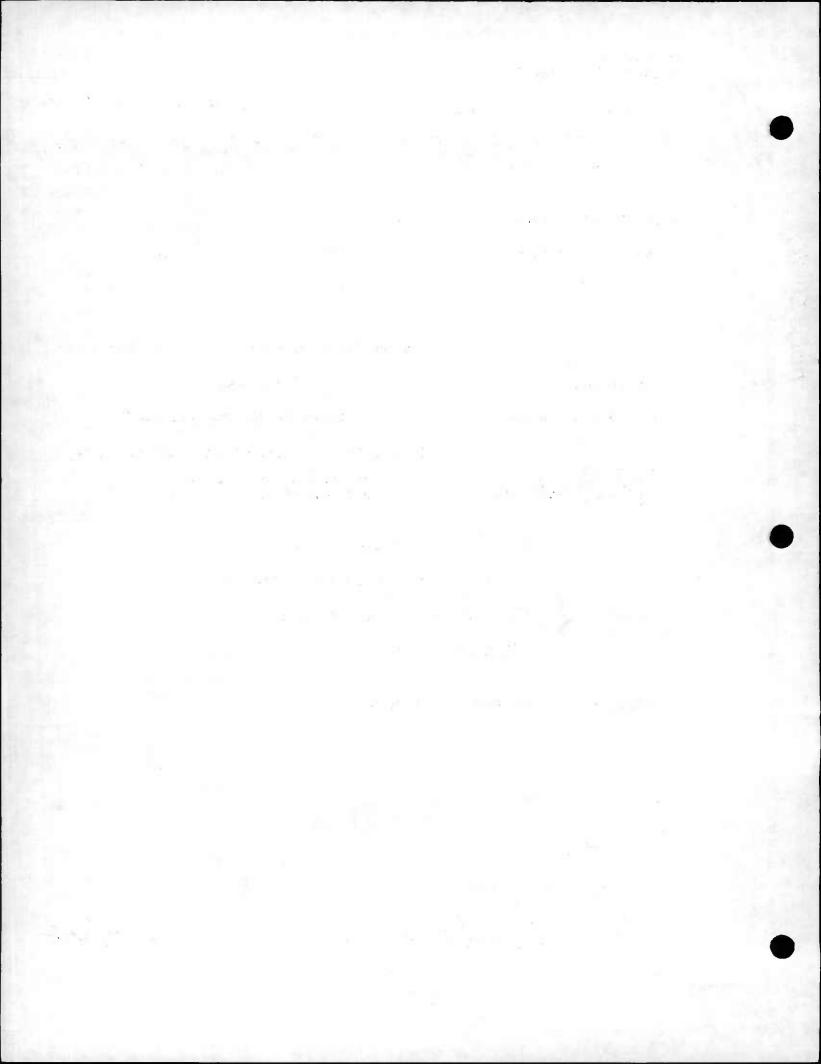
				otato of mary		Certificate of		iorital rry	Reg. No.	0 /	63222
	Physicia	m	1. Decedent's Neme (First, Middle, Last)					2. Dete of De Month	eeth Dey	Yeer	3. Time of Deeth
	/Medica		Donald Vic		old			JULU	10 4	998	11:15 pm
	Examine	er	4a. Fecility Name (If not institution, give:	street and number)	Manl	-01/	4b. City, Town, or Lo	cation of Deat	h 4c. County	of Peeth	nvo.
F	uneral		5. Social Security Number 6. Sec		yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th .	9. Births	place (State or Foreign
	rector			M 2□ F		Yrs. Months Deys	Hours Min.	8. Date of Bir Month, D. July 1	0, 1998	Mary	land
pug g	*	-	Usuel Residence of Decedent 10e. Stete 10b. County	10	c. City, Tow	n or Location				1	IOd. Inside City Limits
with the Maryland	r 28a-f show notified at	to	Maryland Harfo			avre de Gra	ce			1	1 ☐ Yes 200XNo
96	or 28a	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of \	Whet Cour	ntry?
6			4064 Gravel H	ill Road		210	78		U.S	.A.	
200		by Funeral	11. Maritel Stetus 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	rin U,S.	13. Wes Decedent of I If Yes, specify Cub		ecify Yes or No Rican, etc.)	Specify	ck, White,	etc.
215,000			15. Decedent's Educ	Yeer or Detes:	16a	Decedent's Usuel Occup	nation		16b. Kind of B		nite
215	Medic Medic	Completed	(Specify only highest grade	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire	during most of working)	ing	700. Kind of Bi	231110337111	Bushiy
217 W Bell	44	Con	0	0	In	fant		12	Depend		
Due ill	d off	Be	17. Fether's Name (First, Middle, Last) Edward A. Rei	at. blodm			18. Mother's Name			10)	
laryla sand Mor	merk	2	19e. Informent's Neme/Reletionship (Ty)	<u> </u>	19h	. Meiling Address (Street		M. Ash		State 7in	(Code)
N. M	r trau	-	Donna Wertsch (Aun	N		611 N. Adam					
Ore,	r othe		20e. Method of Disposition 1 Brutel 2 □ Cremetion 3 □ R		Ob. Place of	Disposition (Name of y, crematory or other pla		Dete	20c. Location -		
Limited Page	lant: If		4 ☐ Donetion 5 ☐ Other (Specify)	1	Baker	Cemetery	7	/20/98	Aberde	en, M	Maryland
Bal	amy in		21. Signeture of Funeral Bervice License	B. 60	249	22. Name end Addre Tarring Aberdee:	ess of Fecility —Cargo Fur n, Marylar	neral H	ome, P.A	4.	
			23e. Pert1. Enter the disease, or compil shock, or heert failure. List only or	cetions thet caused the le ceuse on each line.	seath. Do r						Approximete Intervel Between
	sician edical		Immediate Cause (Finel	T						l i	Onset and Deeth
-	miner		disease or condition resulting in deeth)	Imma						0	21 Weeks
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acuted	physicien and s the buriel-transit	Examiner	Sequentielly list conditions,	Due	to (or es e o	consequence of):				1	
60,			Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury								
68760,	ng phys	Medical	thet initieted events resulting in deeth) Lest	Due	to (or es e c	consequence of):					
Box lath certi			d								
O. B	ed for	Physician	Pert II. Other significant conditions con	tributing to death but no	ot resulting in	the underlying cause gi	ven in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
P.O.	d by the	Phy						10	Yes 2 No	3 Prof	bably 4 Unknown
ds,	been signed by the should be detached	δ S						040 1460		24b W/	ere eutopsy findings
jo s	noys .	ete						perfe	en eutopsy omed?	eve	ellable prior to impletion of cause
Be la	ate hes	Completed						10	Yes 210 No		deeth? ⊒Yes 2∭(No
ital	certificate	ge C	25. Wes case referred to medical			-	26. Plece of Deeth		-		2 165 2 M 140
of V	direct	9	examiner? 1 ☐ Yes 2 No	ospitel:	2□ER/Ou	tpatient 3□ DOA Oti	her: 4 Nursing Hor			er (Specif	y)
E 8	After th funeral		27. Menner of Deeth 1 Neturel 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. T	ime of 28c. Inju	ry et rk? I Yes 2 □ No	28d. Describe	how Injury occur	red	
/iSiO Attendi	y the	lica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury -	At home, fe	rm, street, fectory, office		28f. Location (Street and Numb	per or Rure	al Route Number,
₹ 5 €	d in t	E	4 ☐ Homicide determined	building, etc. (S	pecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, State)		
DIVISI To the Hospital or Attenwithin 24 hours after deat	Funer tely fill	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my ler: On the basis of exa end menner steted.	y knowledge, minetion end	, deeth occurred at the ti d/or Investigation, in my o	me, dete end piace, a opinion, deeth occurre	and due to the ed et the time,	ceuse(s) end me date end piece,	end due to	teted. o the cause(s)
To the within 2	com		29b. Signature end title of certifier	1		29c. Licens			29d. Date signe		
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F	State Registra	•	31. Dete filed (Month, Dey, Year)	B Salis	uclear A	ardell.					
			AAF 5 . MA	U							



THORN SHIRIEY
Baltimore, Maryland 21215-0020

		07/13/98,bjv,Talbo			Certificate o	Dealli	2. Date of De	Reg. No.07/	15/98	3. Time of Deat
hysiciar		1. Decedent's Name (First, Middle, Las					Month	Day 100	Year	5:28P1
/Medica		Shirley I 4a Facility Name (If not institution, give		norn		4b. City, Town, or	Location of Death	h 4c. County	of Death	J.AOF!
xamine neral ector		NORTH ARUI 5. Social Security Number 6. Social Security Number 11	VSEL I	405P17. ge (In yrs. last bi	Monthe Day	GIEN (3	S. B. Date of Bir (Month, Da	- A.A	9. Birthpl	JUTY lece (Stete or Follow) aware
E ==	-	Usual Residence of Decedent 10e. State 10b. County		10c. City, Tov	n or Location				10	0d. Inside City Lir
be notffied at	0 1	Maryland Anne Aru	ınde1	Hanov	ror					11 Yes 2□
be notifie	9	10e. Street end Number			10f. Zip Code	e		10g. Citizen of V	What Count	try?
Examiner must	by runeral	1408 Macedonia I 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Year or Dates:	?	2107 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Bled	e - America ck, White, e	etc.
dical	erec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a	Decadent's Usual Occ (Give kind of work do	ne during most of we	orking	16b. Kind of B	usiness/Ind	dustry
any injury or other traumatic event, the Medical once. To Be Commissed		Elementary/Secondary (0-12) 12 H 17. Father's Name (First, Middle, Last)	College (1-4or	5+)	Executive	House Wif	e ame (First, Middle			eering
ric ev		Raymond Luke La	ike			Eliza	Mason			
		19a. Informant's Name/Relationship (7		19	o. Mailing Address (Stre			er, City or Town,	State, Zip	Code)
5	2	James Thorn, Hus 20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemete	1408 Maced of Disposition (Name of any, crematory or other p angton Natio	plece)	Date	20c. Location -	City or To	wn, State
ian ical		23a. P. 11 Enter the disease, or composition, or heart failure. List only of the composition of the composit	one cause on each li	ine.	P.O.		Easton,	Md. 21	1601	Approximete Interval Betwee Onset and Dea
ian cal ner	al Examiner	showl, or heart failure. List only o	e. CARDIA b. ATHERO	Due to (or as a Due to (or as a TAGE	P.O. not enter the mode of a pay ARRYTH consequence of): Consequence of): CENAL Disconsequence of):	Box 1687, dying, such as cardia IMIA	Easton, ac or respiretory e	Md. 21	1601	Interval Between
ian ical ner	al Examiner	ship, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e. CARDIA b. ATHERO c. END St. d. HYPER	Due to (or as e DSCIER Due to (or as a TAGE Due to (or as a PRENSIL Due to resulting	P.O. not enter the mode of a part of the consequence of): Consequence of): CENAL Diconsequence of): In the underlying cause	Box 1687, dying, such as cardial HIA DIAL DIS	Easton, ac or respiretory e	Md. 21	ntribute to	Interval Between Onset and Dea
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aroun on constraint and the burnering is a part of the burnering in the burnering is a part of the burnering in the burnering is a part of the burnering in the burnering in the burnering is a part of the burnering in the burnering in the burnering is a part of the burnering in	be completed by rifysiciarymedical Examiner	ship, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions conditions conditions conditions conditions cause. In the cause of the conditions conditions conditions conditions conditions conditions cause cause cause referred to medical examiner?	e. CARDIA b. ATHERO c. END S d. HYPER ontributing to death b	Due to (or as a DSCIER) Due to (or as a TAGE Due to (or as a TENSIC) Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to	P.O. not enter the mode of consequence of): OTIC CARL consequence of): CENAL Disconsequence of): V In the underlying cause	Box 1687, dying, such as cardial AMIA DIAL DISCRETE Given In Pert I.	Easton, ac or respiretory e	Md. 2] Itobecco use co Yes 2 No s an autopsy ormed? Yes 2 No one)	ntribute to 3 Prob 24b. We ave cor of t	the cause of dobably 4 Union of cause and Deal of the cause of dobably 4 Union of cause of the c
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octor, page 2 should be deteched for use as the buriel-transit in grant and in Dhystolan Medical Examined	certification: To be completed by rinysidatemedical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions condi	e. CARDIA b. ATHERO c. END S d. HIPER ontributing to death b EHT GRO Hospital: 1 inpation 28a. Date of Injute (Month, Date of Injute (Month) (Month, Date of Injute (Month) (Month, Date of Injute (Month) (Due to (or as e DSC/ER Due to (or as a TAGE Due to (or as a TAGE Due to (or as a PTENS/L Dut not resulting OIN W Diry Year) 28b. 10ry - At home, for (Specify) of my knowledge of examination elements	P.O. not enter the mode of consequence of): Consequence of): CENAL Disconsequence of): What is the underlying cause of the consequence of the c	Box 1687, dying, such as cardial and place of Dr.	Easton, ac or respiretory e 23b. Did 1	Md. 2] Itobecco use co Itobecco use co IYes 2 No san autopsy ormed? Yes 2 No one) idenca 6 Oth how injury occur (Street and Numb iwn, State)	ntribute to 3 Prob 24b. We ave cor of c	Interval Betwee Onset and Deal onset

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey Month Yeer **Physician** 12, 1998 EDWIN STEPHENS VALLIANT, JR. JULY 8:12 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** QUEEN ANNE'S CORSICA HILLS CENTREVILLE If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1⊠M 2□ F 89 Yrs Director 213-09-9508 OCT.20,1908 MARYLAND Usual Residence of Decedent with the Marylend 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treatmetic event, the Medical Examiner must be notified at once. 1 to Yes 2 □ No MD QUEEN ANNE'S CENTREVILLE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 CHESTERFIELD AVE. 21617 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Merital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. þ WHITE 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Spacify only highast grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 11 EXECUTIVE FERTILIZER COMPANY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Surneme) Be EDWIN STEPHENS VALLIANT NELLIE HALL 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SARA CATHERINE VALLIANT/ WIFE P.O. BOX 320, CENTREVILLE, MD 21617 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata ST.LUKE'S CHURCH CEMETERY 7-15 CHURCH HILL, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Nama and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical DO naT 2095 Examiner Physician/Medical Examiner law requires that the death certificate be executed physiclan end s the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760 Due to (or es e consequence of): d for use as t signed by the el 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the undarlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, Q 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Is certificate hes I 1 Yes 2 No 1 Tyes 2 □ No Division of Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 45 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 DNatural 5 Pending efter death. Director: Af 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 6 24 hours efter re Funeral Dire pletely filled in b 4 Homicide Hospital edicai 29a. Certifier 1D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner steted. 29b. Signature and title of confiler 29c. License number 29d. Date signed (Month, Dev. Year) uce 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

RUSSELL SCHILLING, M.D., NORTH LIBERTY ST., CENTREVILLE, MD 21617

Julia Davidson-Randell

32. Registrar's Signature

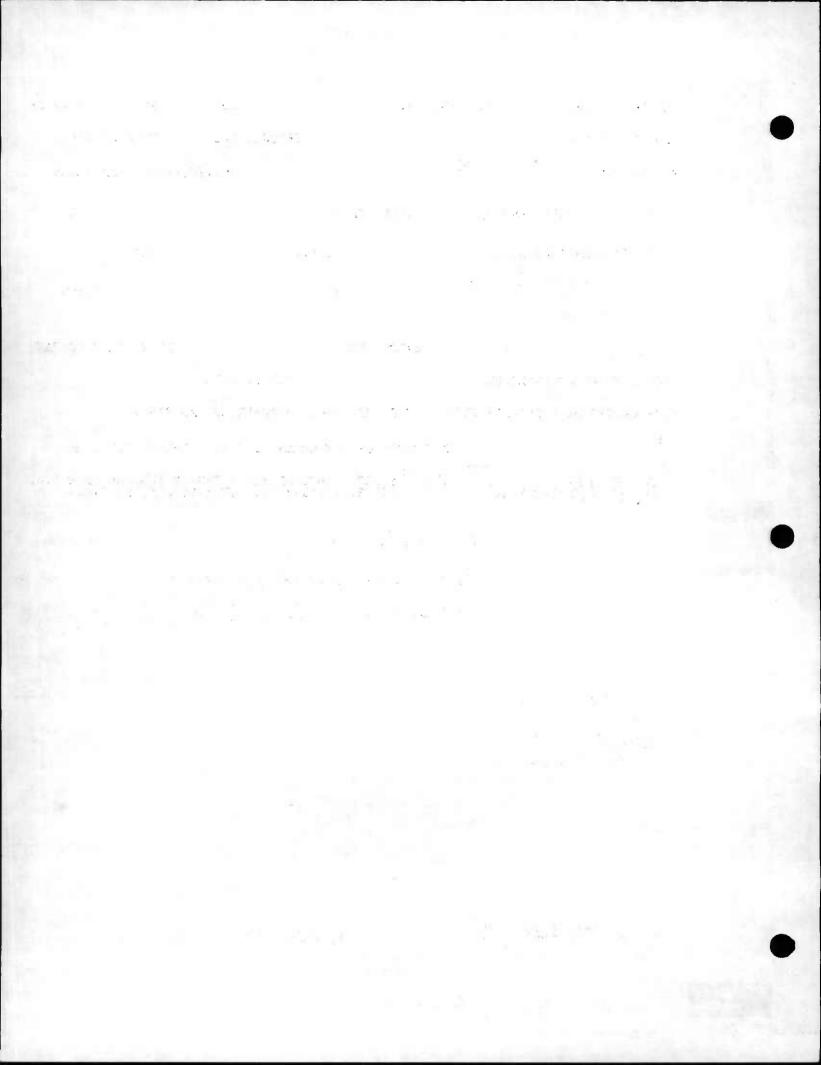
DHMH 16 Ray 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 4 1998



			State of Mary			of Health and of Death		ene	232	25	
		1. Decedent's Name (First, Middle, Las	ot)				2. Dete of Deeth	Day V		. Tima ol	Deeth
	sician edical	Dorothy	Barbara	WYNNE			JULY 10		aer 1	:34	PM
	miner	4e Fecility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County of	Deeth		
•		THE MEMORIAL				EASTO		TALBO			
Fune Direct		213-26-3469	THE WINE	yrs. lest birthdey) Yrs.	Months D	Year If Under 24 Hrs Deys Hours Min.		(ear) 1930	. Birthpleca Country)	MD	r Foreign
bud **		Usuel Residence of Decedent 10a. Stete 10b. County	10	c. City, Town or Lo	ocation				10d.	Inside Cit	ty Limits
filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. Indier then "natural", or items 23s or 28s-f show mit.	ō	MD Queen A	Anne	Ches	ster					1 🗆 Yes	2 No
the 128a	Funeral Director	10e. Street end Number			10f. Zip Co	ode	109	g. Citizen of Wh	et Country?	,	
3a o	0	1808 St. Mary	s Road			21619	9	U	.S.A		
deeti	Der	11. Maritel Stetus	12. Was Decedent Ever Armad Forces?	in U,S. 13.	Was Deceden	t of Hispenic Origin? (S Cuban, Mexicen, Puer		14. Race -	Amaricen I White, atc.	Indian,	
after or ha	5	1 ☐ Navar Married 3 ☐ Married	1 Tas 2 No		1 ☐ Yes 2 🎖		(0 / 110411, 010.)				
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72 hours after deeth w natural', or itsms 23a	e e	15. Decedent's Ed (Specify only highest gra	ucation de com <i>pleted)</i>	(Give	dent's Usuel C kind of work of	fone during most of wo	rking	6b. Kind of Bush	ness/Indust	ry	
within the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use r			Oh amai	on D	0-14	
Hygie	ပိ	12 17. Fether's Neme (First, Middla, Last)	3	Rea.	LESTA	te Agent	me (First, Middle, Ma	Champi	OII K	eart	- Y
should be filed within and Mentel Hygiene. marked other than their	o Be	Leonard Wrze	sinski			Clara	Milwicz				
d 2 should be filed within the and Mentel Hygiene. 7 is marked other then	F	19a. Informent's Name/Reletionship (7		19b. Maili	ng Address (S	treet end Number or R		City or Town, St	ete, Zip Cod	de)	
1 end 2: Health er em 27 is		Clyde Wynne/ H	ısband	1808	St. M	lary's Ro	ad Ches	ter, M	D 2	1619	}
8 5 5		20a. Method of Disposition	2	Ob. Pleca of Dispo		of		Oc. Location - Ci	ty or Town,		
permit. Pages Depertment of Important: If Ite		1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify	Entombren				ulv 14.1	Annap	olis	, MI)
permit. Depente	Souce	21. Signatury of/Funeral Service Licen	4	2:	2. Name end A	Address of Fecility					
205	8	May AN	Phile	S Fe	ellows	, Helfen	bein & N	ewnam	Fune	ral	Home
	8	23a. Part V Enter the disease, or contrained, or heart failure. List only	plications that caused the	Do not en	lester ter tha mode o	dying, such as cardia	c or respiretory erres	st,	Ap	proximate ervel Betv	a
Physici	an		-	/						nset end D	
/Medic Examin		Immediate Ceuse (Final disaese or condition	. Pheum	onia					7	do	10.
Examin	100	resulting in deeth)	Due	to (or es e conse	quence of):				I	(0
po is	Examiner		b								
icate be executed physician end sthe buriel-transit	хап	Sequentially list conditions, if env. leading to immediate	Due	to (or es e conse	quence of):				į		
be e	<u>e</u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	с.								
ficate phys	edicai	that initiated events resulting in deeth) Lest	Dua	to (or es a consec	quance of):				-		
certi	2		d						-		
death death	Cla	Pert II. Other significant conditions of	potributing to deeth but no	ot resulting in the I	indedylna caus	se given in Pert I	23h Did toh	acco usa contr	ibute to the	e cause c	of death?
t the	Physician/M	Concertion her	AC. 0	A		0001	1 Yes	1.3	☐ Probabi		
s the	by F	00.905/100	Tancon	1-Janes	mysce	ent interes	100	,			
Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician end rial director, bene 2 should be deteched for use as the buriel-transit	Completed	Acute und Fo	ulupl	- 14			24a. Wes an perform			ble prior to letion of ca	0
he la e he:	E O						1 ☐ Yes	2 No	1□ Ye	es 2	No
sicilar: The law s certificate hes bijrector, pege 2 s	BeC	25. Was case referred to medical				26. Plece of De	eth (Check only one	7797			
yalclı s cer direc	TO B	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpetie	nt 3 DOA	Other	lome 5 ☐ Residen		(Specify)		
G Ph	Ë	27. Manner of Deeth	28e. Dete of Injury (Month, Dey Ye	ar) 28b. Time o	f 28c.	Injury et Work?	28d. Describe hov	v Injury occurred	1		
ath.	atio	1 Accident 5 Panding investigation			М	1 ☐ Yes 2 ☐ No					
s efter de	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (S	At home, larm, st ipecify)	reet, lectory, o	ffice	281. Location (Stre City or Town,		or Rurel Ro	outa Numi	ber,
To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, consoletely filled in by the funeral director, cooper	edical		ysicien: To the best of my liner: On the bests of exe end menner steted.	mination end/or in							;)
To the Vithin	Me	29b. Signature and Title of Contiller			29c. L	icense number		d. Date signed (Month, Dey	v. Year)	
- >- 0		1/4/1/	my		0	39749	7	110/98			

M.D. 503 Dutchmans Lane Easton, MD 32. Registrer's Signeture

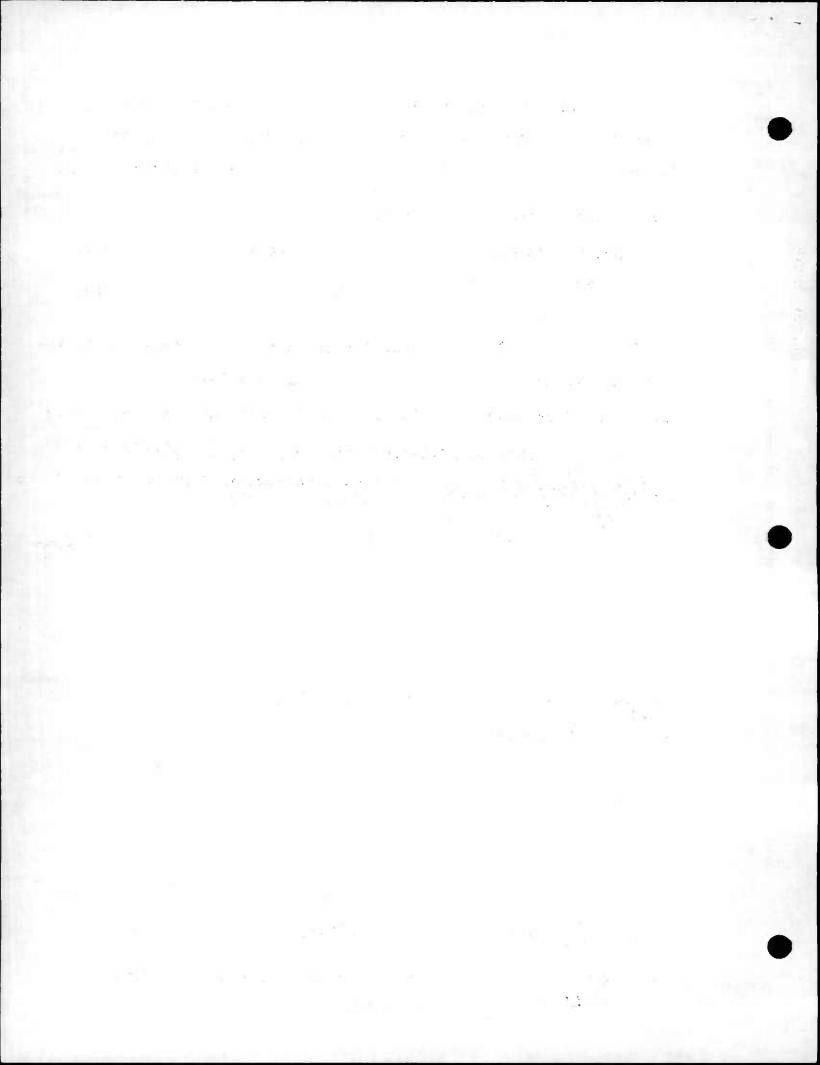
... a Davidson-Randelle

State Registrar

30. Name and addrass of person who completed cause of deeth (Item 23e) (Type, Print)

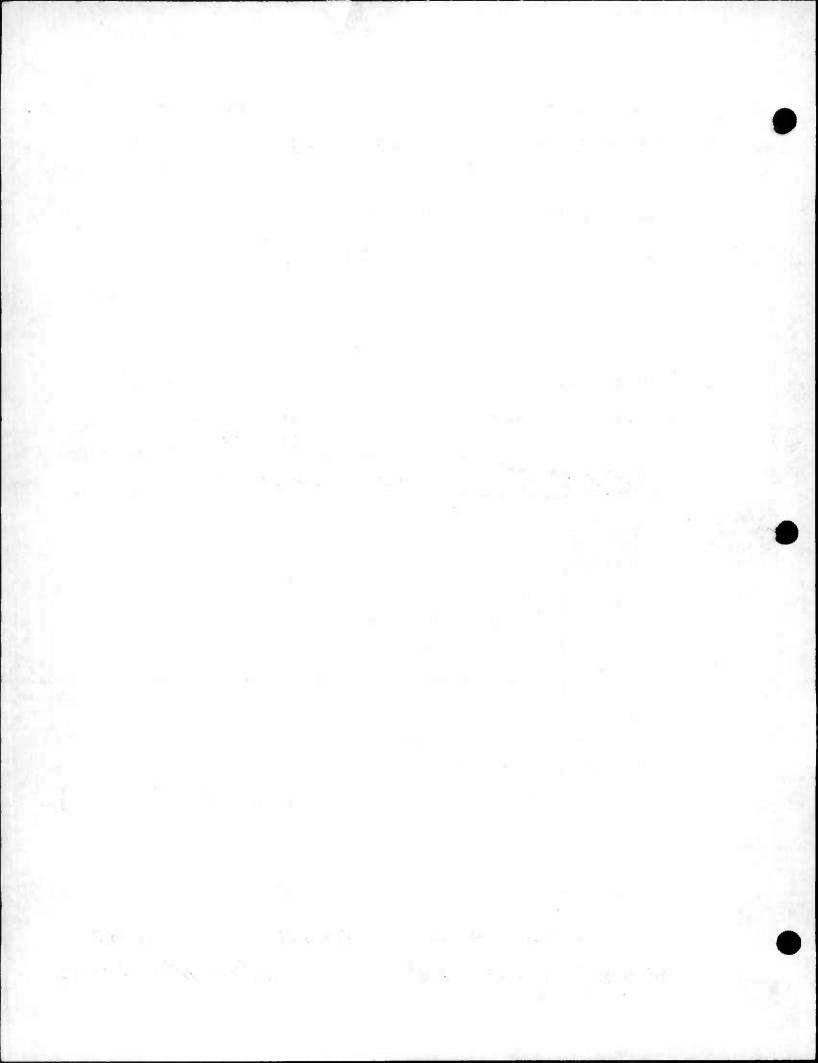
M.D.

D. Greg Oliver,
31. Data filed (Month, Pay, Yaar)
11. 1998



220-34-4573 Usuel Residence of Decedent 10a. State 10b. County Maryland Charles 10e. Street end Number #3 Poplar Lane 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorcad 15. Decedent's Ec (Specify only highest green in the status) Elementery/Secondery (0-12) 11 17. Fether's Neme (First, Middle, Last) Budd Andrew Hancoo 19e. Informent's Neme/Relationship (1) Ruby Dyson 20e. Mathod of Disposition 1 Burial 2 Cremetion 3 Deceden in the status in th	Wax ve street and number) Ursing & Reha Sex 7. Age (In) 92 10c. 12. Was Decedent Evar In Armed Forces? 1	rs. last birthday) Yrs. City, Town or Lo India: 16e. Dece (Give life. Home: 19b. Mallii P.O b. Plece of Disponantary, cree	ion If Under 1 Year Months Days coation In Head 10f. Zip Code 20640 Was Decedent of Hif Yes, specify Cub- If Yes, specify Cub- If Yes 25 No dent's Usual Occup kind of work done DO NOT use retires maker ng Address (Street Box 217	Hours Min. Hispenic Origin? (Spen, Mexican, Puerto Specify: Detion during most of work d) 18. Mother's Nam Mary E] Pend Number or Flur. 7. Tronsic	ecify Yes or No Rican, etc.) ing a (First, Middle, izabeth	Dey 1998 1998 1098 1098 1098 1098 1098 1098	of Deeth arles 9. Birthplece (Country) 06. Mary 10d. In 11 Whet Country? e - American Inck, White, etc. White usiness/Industry	2
4e. Fecility Neme (If not institution, given Charles County Nt. 5. Social Sacurity Number 6. Social Sacurity Number 10a. State 10b. County Maryland Charles 10b. Street end Number 10b. Street end Number 11b. Maritel Status 1 Never Married 2 Married 3 Middle 1 Divorcad 15. Decedent's English Maritel Status 15. Decedent's English Middle 1 Divorcad 15. Decedent's English Middle 1 Divor	Pe street and number) UTSING & Reha Sex 10	rs. last birthday) Yrs. City, Town or Lo India: 16e. Dece (Give life. Home: 19b. Mallii P.O b. Plece of Disponantary, cree	ion If Under 1 Year Months Days coation In Head 10f. Zip Code 20640 Was Decedent of Hif Yes, specify Cub- If Yes, specify Cub- If Yes 25 No dent's Usual Occup kind of work done DO NOT use retires maker ng Address (Street Box 217	Hispenic Origin? (Spen, Mexican, Puarto Specify: Detion during most of work d) 18. Mother's Name Mary Eleman Number or Runner of Number of Numbe	ecity Yes or No Rican, etc.) ing a (First, Middle, izabeth	th, Yeer) Y 25, 19 10g. Citizen of W U.S.A 14. Rac Blec Specify 16b. Kind of Bu Her Ho Maiden Sumem COOKSE ar, City or Town,	of Deeth arles 9. Birthplece (Country) 06 Mary 10d. In 11 Whet Country? e. American Inc. white, etc. White	(Stete or Foreign yland nside City Limits XYes 2□ No
Charles County No. 5. Social Sacurity Number 6. 8. 220-34-4573 Usuel Residence of Decedent 10a. State 10b. County Maryland Charles 10e. Street end Number #3 Poplar Lane 11. Maritel Status 1 Never Married 2 Married 3 X Widowed 4 Divorcad 15. Decedent's Enementery/Secondery (0-12) 11 17. Fether's Neme (First, Middle, Last) Budd Andrew Hancoc 19e. Informent's Neme/Relationship (18 Ruby Dyson 20e. Mathod of Disposition 1 Burial 2 Cremetion 3 Decedent 15 Dottar (Specify County Dyson 20e. Mathod of Disposition 1 Burial 2 Cremetion 3 Decedent 20e. Signeture of Funeral Service Licen 2015 Proposition 1 Signeture of Funeral Service Licen 2015 Proposition 1 Signeture of Funeral Service Licen 2015 Proposition 1 Signeture of Funeral Service Licen 2015 Proposition 2015 Proposition 1 Signeture of Funeral Service Licen 2015 Proposition 2015 Pr	12. Was Decedent Evar In Armed Forces? 1	rs. last birthday) Yrs. City, Town or Lo India: 16e. Dece (Give life. Home: 19b. Mallii P.O b. Plece of Disponantary, cree	ion If Under 1 Year Months Days coation In Head 10f. Zip Code 20640 Was Decedent of Hif Yes, specify Cub- If Yes 25 No dent's Usual Occup kind of work done DO NOT use retires maker ng Address (Street Box 217	Hispenic Origin? (Spen, Mexican, Puarto Specify: Detion during most of work d) 18. Mother's Name Mary Eleman Number or Runner of Number of Numbe	ecify Yes or No Rican, etc.) ing a (First, Middle, izabeth	10g. Citizen of V U.S.A 14. Rac Blec Specify 16b. KInd of Bu Her Ho Maiden Sumem COOKSE ar, City or Town,	9. Birthplece (Country) 9.6 Mary 10d. In 11 Whet Country? e. American Inc. K, White, etc. White	yLand nside City Limits X Yes 2□ No dian,
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21. Signeture of Funeral Service Licen	Fo		~	[∞] July 17,	1998	Manhana	Magazz	224
11/1/		22	Cemetery 2. Nama end Addre	ss of Facility		Marbury	, Maryı	and
	011	TAT	illiams H	hineral Ho	ome, P.A	Α.		
23a Part Enter the scans or com	MOO	668 4	270 Hawth	orne Rd.,	Indian	Head,	Md. 206	
shock, or heart ail e. List only	one cause on each line.	eetn. Do not ent	er tha mode of dyli	ng, such as cardiac	or raspiratory ai	rrast,	Inten	roximeta vei Between et end Death
Immediete Cause (Final	_	1	11 4	- 1			Onse	st ond Death
diseese or condition resulting in deeth)	a. Concy	where	Heard	1-arlune	-			
	Dueto	o (or es e consec	quence of):	11 + 1				
Consumption that any distance C	b. Out	hero su	Levaler	Heart 1	Holen	٠	İ	
if eny, leeding to Immediate cause. Enter Underlying		+ 0	juenca orj.	L				
Cause (Disease or injury thet Initieted events	c. Due to	(or es e conseq	uende of):	Lien				
rasuring in death) Last		(30.1.25				į.	
	d						1-	
Pert II. Other algnificant conditions or	ontributing to death but not	resulting in the u	nderlying cause giv	ren in Pert I.	23b. Did 1	tobacco uae cor	ntribute to the c	cause of death
OLD ELLO	1							-1
Music Palitta	llen							
St. Pot	(.0			24e. Wes	an eutopsy	24b. Were eu	topsy findings
Jeans 4 bit	Caliona	cocas			pono	····ou ·	complete of deeth?	ion of causa
anema					101	res 20 Na		
25. Wes case referred to medical				26. Piece of Deeth				
1 Yes 2 No	Hospitei: 1 Inpatient 2	☐ ER/Outpatian	t 3 DOA Oth			-	er (Specify)	
27. Menner of Deeth	28e. Dete of Injury	28b. Time of	28c. Injur					
2 ☐ Accident Invastigation		, injury						
3 ☐ Suicide 6 ☐ Could not be determined	28e. Piece of Injury - A	t home, farm, stre	eet, factory, offica		28f. Location (S	Street end Number	er or Rural Rout	te Number,
	bullding, etc. (Spe	icity)			City or Ton	ni, Siela)		
29e. Certifier 1 Certifying Phy	ysician: To the best of my k	nowledge, deeth	occurred at the tin	ne, dete end plece,	end due to the	cause(s) end me	nner es steted.	
one) 2 Medical Exam	and menner steted.	inetion and/or inv	estigation, in my of	pinlon, death occurr	ed et the time, o	dete end place, e	end due to the co	euse(e)
29b. Signeture end title of certifier	0		29c. License	e number		29d. Data signed	(Month, Day, Y	(ear)
1 Jm	1 & Soula	N	00	1009		7-16	4-98	
30. Nemeand address of person who c	completed cause of deeth (II	tem 23e) (Type, I			4	1	. 4	
OKNEY L.	BURKE	MAN		1.00	400	MI	206	40
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Daath 1. Decedant's Nama (First, Middla, Last) Month Day Voer **Physician** CHRISTOPHER 1998 HENRY WIEMER JULY 16 7:30 AM /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 610 WAYSIDE AVENUE EASTON TALBOT If Undar 24 Hrs. Hours Min. If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months 1X M 2□ F Director 93 OCT. 8 1904 063-07-8194 NEW YORK Usual Residence of Decedant with the Marylend 10a. Stata 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f show enty injury or other treumatic event, the Medical Examiner must be notified at once. 10b. County 1 Vas 2 □ No MD TALBOT EASTON Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 610 WAYSIDE AVENUE 21601 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 No Il Yas, Giva Yaar or Datas: 1 Navar Married 200 Married altimore, Maryland 21215-0020 1 Yas 2 Tylo Specify: Specify: WHITE þ 3 Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATION HOSPITAL 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be CHRISTOPHER WIEMER 2 MARIE CORVEY 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) RUTH B. WIEMER/ WIFE 610 WAYSIDE AVENUE, EASTON, MD 21601 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition

1 Burial 2 Scamation 3 Removal from State 20c. Location - City or Town, Stata CHESAPEAKE CREMATION CTR. 7-17 CHESTER, MD 4 ☐ Donation 5 ☐ Othar (Specify) of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility OFELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 2160 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Batwean Onset and Death **Physician** /Medical Immediata Causa (Final mos disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of): Examiner The law requires that the death certificete be executed ician and buriel-trans Sequantially list conditions, if any, laading to immediate ceuse. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Due to (or as a consequence oi): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical the Dua to (or as a consaguance of) 8 23b. Did tobacco usa contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by t should be detach 1 Yes 2 1 No 3 Probably 4 Unknown by 24b. Ware autopsy lindings available prior to complation of causa of daath? 24a. Wes en autopsy Completed parformed' page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician: funerel director, 25. Was case raterrad to medical Be 26. Place of Death (Check only sha) Other: 4□ Nursing Homa 5 🗹 Residence 6 □ Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manper of Deeth 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Neturel efter death.

Director: Aft 2 Accidant To the Hospital or Attervition 24 hours effer der To the Funeral Director completely filled in by the 3 Sulcide 6 Could not ba determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At homa, larm, straat, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifiar 1111 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mannar es stated. edicai (Check only one) 2 Medical Examinar: On the basis of axaminetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year)

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M.D.,

32. Registrar's Signature

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

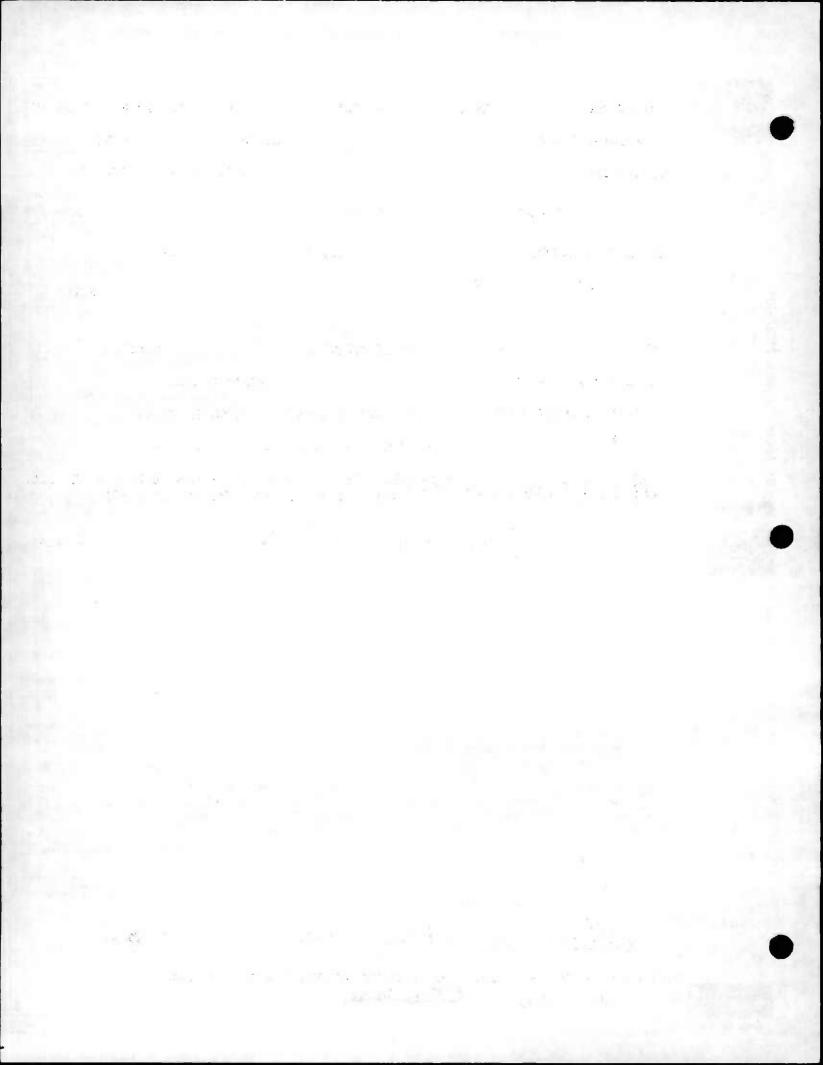
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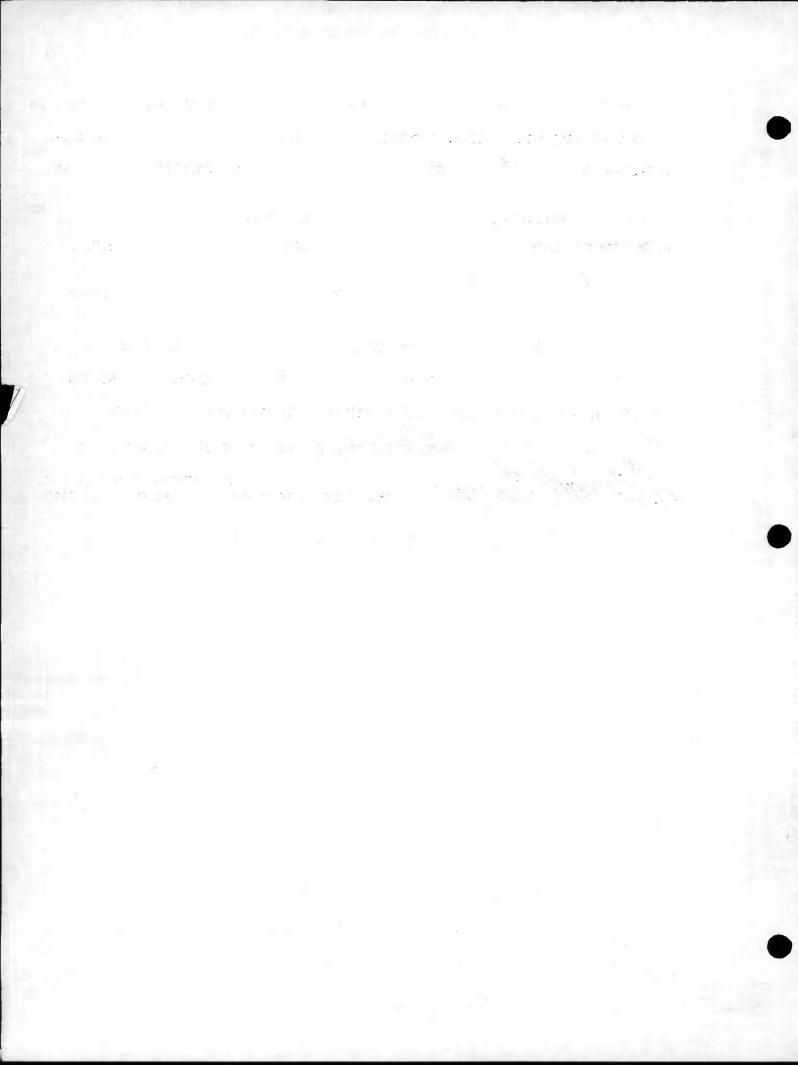
506 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					(Certifica	ate of	Death			Reg. No.		
	1. Decedent's Name (First, N	iddle, Las	t)							2. Data of De	ath Day	Yaar	3. Time of Death
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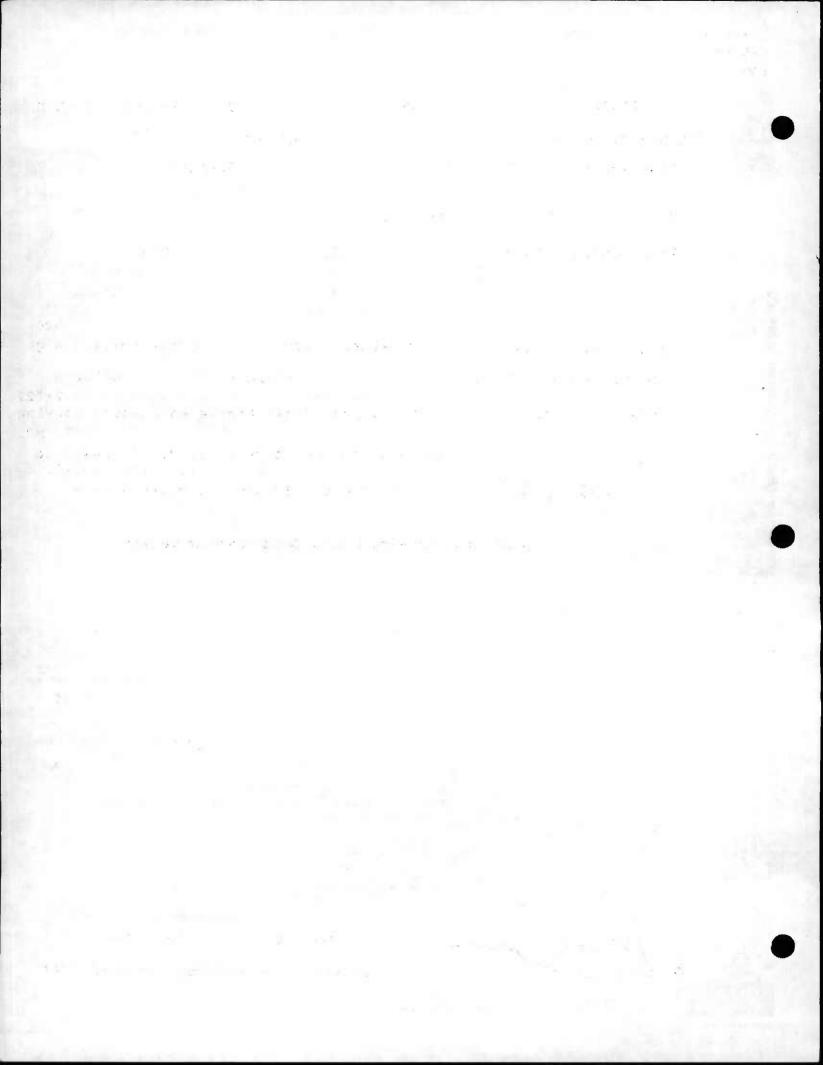
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Registrar

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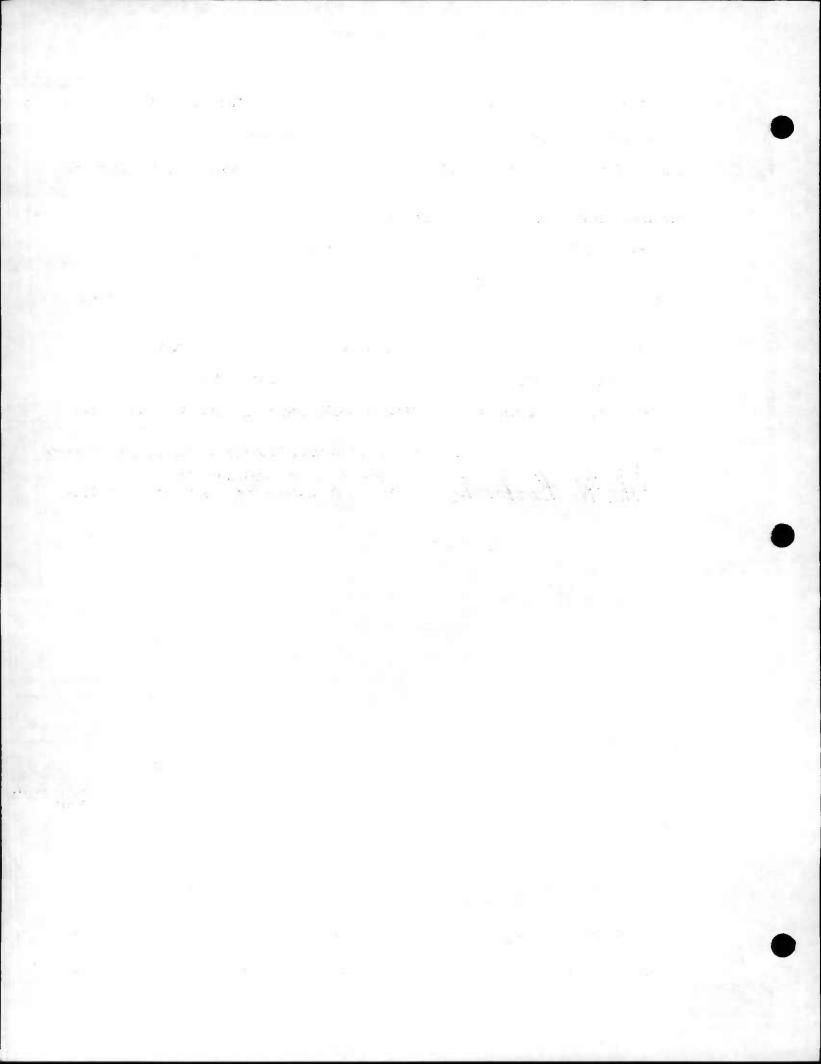
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32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 23230

Anna E. 4a Facility Name (If not institution, g 8144 Windmill Co 5. Social Security Number 213 01 2838 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo 10e. Street and Number 314 Miles Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementery/Secondery (0-12) 8 17. Fathar's Name (First, Middle, Latter) 19a. Informant's Name/Relationship Frances Harlow	Sex 7. Age 1	16a De	Location 2X 10f. Zip Co	Sever If Undar 24 Hrs year If Undar 24 Hrs ways Hours Min	8. Date of Birth (Month, Day, NOV . 8	Anne Arur Year) 9. Bir 1919 Mar	1:00 am andel Indel
8144 Windmill Co 5. Social Security Number 6. 213 01 2838 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo 10e. Street and Number 314 Miles Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementery/Secondery (0-12) 8 17. Fathar's Name (First, Middle, Later Charles H. 19a. Informant's Name/Relationship	Sex 7. Age 1	78 Yrs 10c. City, Town of ESSE Ever in U.S. 1	Months E Location X 10f. Zip Co 3. Was Deceden if Yes, specify	Sever If Undar 24 Hrs year If Undar 24 Hrs ways Hours Min	8. Date of Birth (Month, Day, Nov. 8,	Anne Arur Year) 9. Bic 1919 Mar	ndel Inthplace (State or Foreign country) yland 10d. Inside City Limits 1 Yes 2 No
5. Social Security Number 213 01 2838 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo 10e. Street and Number 314 Miles Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementery/Secondery (0-12) 8 17. Fathar's Name (First, Middle, Latter) Charles H. 19a. Informant's Name/Relationship	7. Age 1 M 2 F 7. Age 1 T F 7. Age 1 T F 7. Age 1 T F 8 T F 8 T F 8 T F 9 T 9 T F 9 T 9 T 9 T 9 T 9 T 9 T 9 T 9 T 9 T 9 T	78 Yrs 10c. City, Town of ESSE Ever in U.S. 1	Months E Location X 10f. Zip Co 3. Was Deceden if Yes, specify	rear If Undar 24 Hrsays Hours Min	8. Date of Birth (Month, Day, NOV . 8	Year) 9. Bin C 1919 Mar	rthplace (State or Foreign ountry) yland 10d. Inside City Limits 1 Yes 2 No
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Charles H. 19a. Informant's Name/Relationship		НС	usewife			Own Home	
19a. Informant's Name/Relationship				1	me (First, Middle, N		
	Rode	1		Ann			
	(daughter)			ireet and Number or F ill Court		City or Town, State, Maryland 2	
20a. Method of Disposition	(daugitter)					20c. Location - City o	
1 Burial 2 ☐ Cremation 3		20b. Place of Di cemetery,					
4 ☐ Donation 5 ☐ Other (Spec		Gardens		n Cem. 7/3	1/1998 B	arto. co.	Maryland
Q. (0 1		Bruzdzi	nski Funer	al Home P	A	
youn N.	Durkous	Q I	1407 Ole	d Eastern	Ave Essex	, Maryland	
23a Party. Enter the disease, or co	mplications that caused ly one ceuse on each lin	the death. Do not no.	antar tha moda o	f dylng, such as cerdia	c or respiratory arre	est,	Approximate Interval Between
L	0	1-	^-				Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. 15\	east	an	cer			yys.
Toodking at Godest)		Due to (or as a con	sequence of):				9
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Sequentially list conditions, if any, leading to immediate		Due to (or as a con	sequence of):				
Ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events	с.		0				
resulting in death) Last		Due to (or as a con	sequence or):				
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Death Other desidence and the				an aliver to Don't	OOL Did sol	h	to to the same of death 2
Part II. Other algoriticant conditiona	contributing to death bu	it not resulting in th	e underlying ceus	se given in Part I.			re to the cause of death? Probably 4 □ Unknown
						202110 3	Tobably 4 Olikilowii
							. Were autopsy findings available prior to completion of cause of daath?
1 1 1 1 1 1					1 □ Ye	s 20XNo	1 ☐ Yas 2 ☐ No
25. Was cese referred to medical				26. Plece of De	eath (Check only one	e)	
examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpa	tient 3 DOA	Other: 4 Nursing	Home 5 ☐ Reside	nce 6 XOther (Sp	Daughter'
Z L / NOCIOOTIC	28a. Date of Injur (Month, Day		e of 28c	-			» Tione
3 Suicide 6 Could not 4 Homicide determine	289. Place of inju	iry - At home, farm :. (Specify)	street, factory, o	ffice			łural Route Number,
	aminer: On the basis of	examination and/o					
29b. Signeture and title of certifier					-	9d. Data signed (Mor	nth, Day, Year)
	an			D39505		July 20	7,1998
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) onar	Markan	1600 €	rain t	wy, Gol	en Bw	mie p	10.21061
F 2	25. Was cese referred to medical examiner? 1 Yes No 27. Manner of Deeth Naturel 5 Pending investigat 3 Suicide 4 Could not determine 29e. Certifier (Check only one) 29b. Signeture and title of certifier	25. Was cese referred to medical examiner? 27. Manner of Death 28. Date of Injunction of Injunctio	Due to (or as a conservation of the condition of the cond	Due to (or as a consequence of): d	Due to (or as a consequence of): d. 25. Was cese referred to medical examiner? 1	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or an anticopy performed? Due to (or anticopy performed? Due to (or anticopy performed? Due to (or anticop



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #1 Per MD , 8 Per FH Film G761 7-30-98RC Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Deeth **Physician** TERRENCE Brown 14:32 98 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nama (If not institution, giva street and number) **Examiner** University of Maryland Medical System Baltimore Baltimore If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax 9. Birthplaca (Stata or Foraign **Funeral** 10M 20 F 212-53-893 Usual Rasidence of Decedent Yrs. Director Pla 6/14/98 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Heelth and Mental Hygiene.
Important: if item 27 is marked other than "naturel," or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Director 10g. Citizan of Whet Country? 10e. Street and Number DIC 2121 220 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1₽Naver Marriad 2 Married 1□Yas 2₽No Baltimore, Maryland 21215-0020 Specify: Black ģ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion
(Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast greda completed) 16b. Kind of Businass/Industry Collaga (1-40,5+) Elamantary/Secondary (0-12) 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be 2 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) EUTAW Place grandmithy 2525 EU (20b. Place of Disposition (Neme of cematary, cramatory or other place) 708 BALTIMOKEMDZIZIT 20a. Mathod of Disposition Data Burial 2 □ Crametion 3 □ Removal from Steta 7/28/98 , 210N 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funaral Sawica Licensaa 22. Nama and Addrass of Facility 38 N 1 MUREMONIZI 23a, Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line. Approximate Interval Between Onsat and Death **Physician** Immediate Ceuse (Finel diseesa or condition rasulting in daath) /Medical Entero colitis hours Necrotizina **Examiner** Due to (or as a consequence of) Physician/Medical Examiner 38 days trematurity certificate be executed nding physician and use es the bunal-tran Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Records, P.O. Box 68760 that initiated avants resulting in death) Lest Due to (or es e consequance of): signed by the Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Intraventricular Hemorrhage by 24b. Wera autopsy findings available prior to completion of causa of death? Hemorrhage 24a. Was en autopsy Completed Intra Cranial After this certificate has 1 Yas 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 (2) Inpatiant Lo 2 ER/Outpatient 3D DOA Hospital or Attending Ph.
 24 hours efter deeth.
 Funeral Director: After the Certification:

	axaminar?		to illegical	
_		-		
27.	Manner of	Death		

28a. Data of tnjury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how Injury occurred

1 Naturel 2 Accidant

3 Suicida

4 Homicida

5 Pending Investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, afc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifian

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar L. Hawkins - Wolt MD 29c. License number

29d. Data signed (Month, Day, Year) 98

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

S. Greene St. Baltimare, MD Z1201 Melissa L Hawkins-Holt MD 22

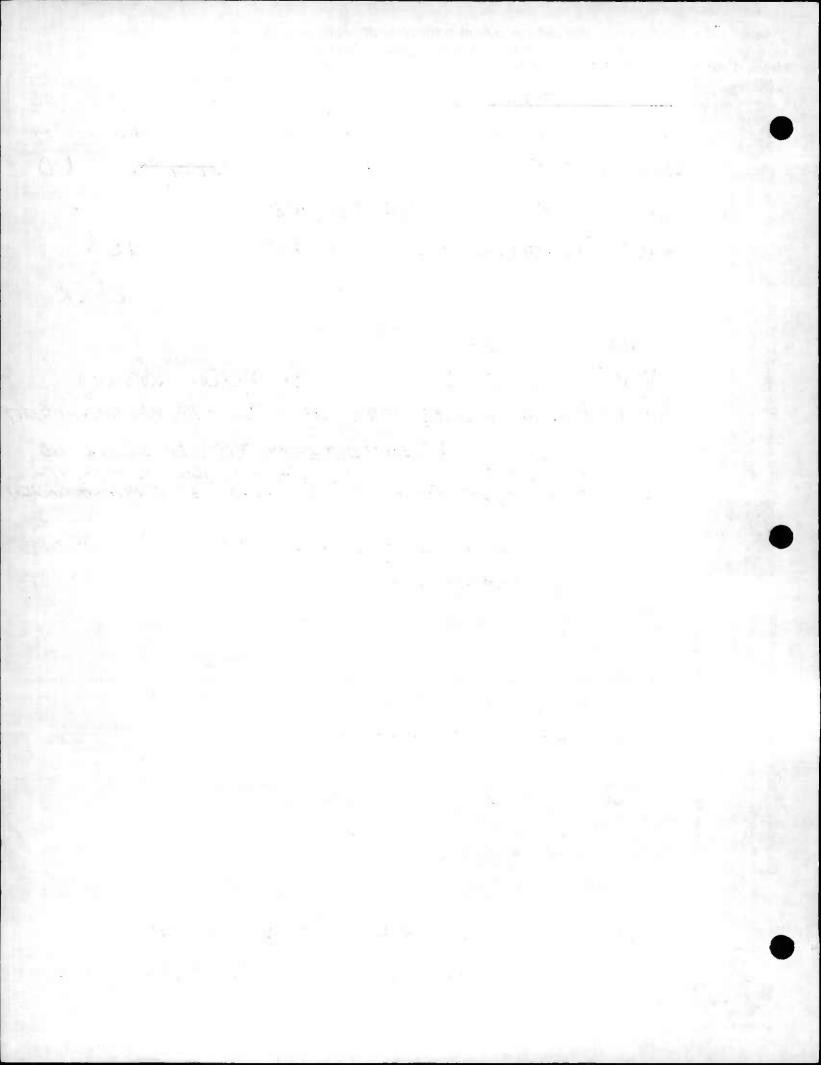
State Registrar

Medical

31. Dete filed (Month, Day, Yaar) 32. Ragistrar's Signature JUL 3 0 1998

Julia Davidson-Randelle

To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the



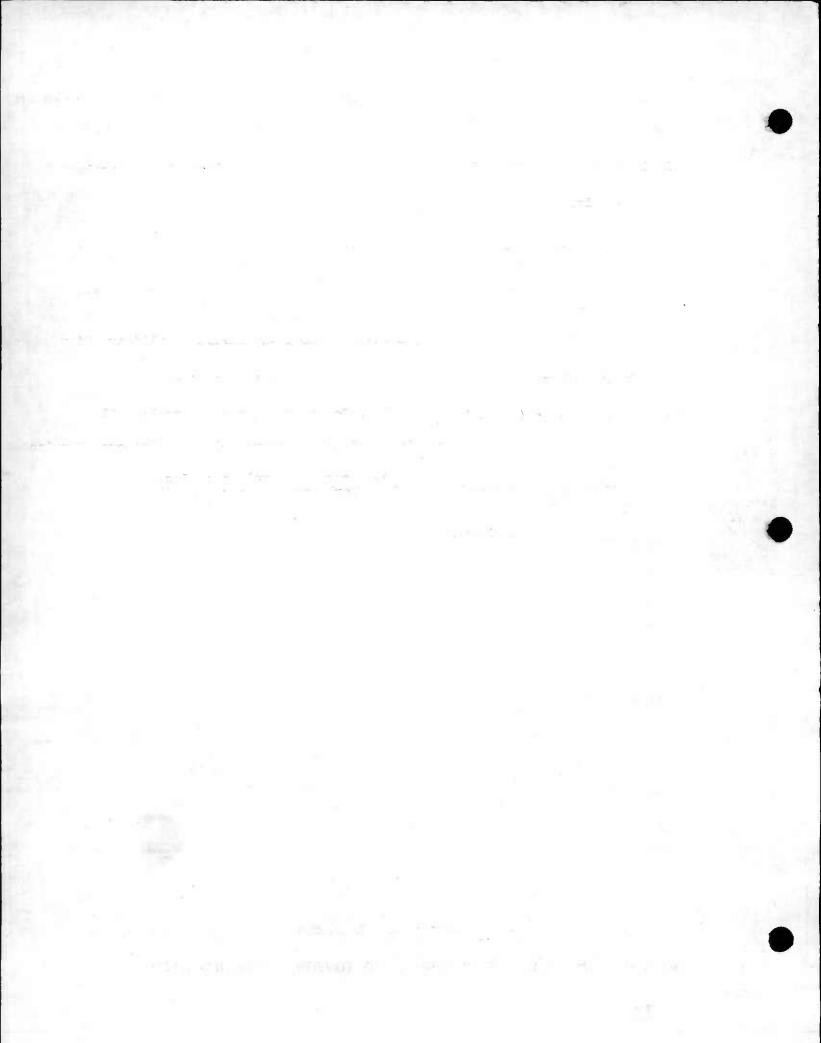
Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month JULY Pay 8, 1998 11:40 PM **Physician** VIRGINIA BAKER /Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner Center Towson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1□M 20 F Yrs. 215-18-3901 76 Director 8-16-1921 Maryland Usual Residence of Decedent 10a. Stete
Maryland Baltimore 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Towson or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Nerne 23a 611 W. Joppa Road 21204 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours after ty Never Merried 2 Merried 1 ☐ Yes 2√ No Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Baltimore City Recreation & Parks Supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is merked oths any injury or other treumstic event aloss. 18. Mother's Name (First, Middle, Maiden Sumeme) 17, Father's Neme (First, Middle, Last) Be Frank Baker Hattie Jelinek 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Robert E. Baker (Nephew) 611 W. Joppa Road, Towson, Maryland 21204 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bohemian National Cemetery 8-1-98 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Wallace Ruck Towson Funeral Home, Inc. Brooks, Dr. 1050 York Road, Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** PNEUMONIA Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest and Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? deteched signed by d be defect 1 Yes 2 No 3 Probably 4 Vunknown DEHYDRATION Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy DIABETES MELLITUS page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral c 27. Menner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) After 1 Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homloide To the Hospital or within 24 hours aft To the Funeral Di completely litted in 29e. Certifier 🖎 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 37254 28 ROOM 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
BOON P. LIM, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 0

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

3 0 1998

32. Registrar's Signeture



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28a-f show notified at rector	10a. State 10b. County		10c. City, Town o							nside City Limits ⊠ Yes 2 □ No	
Director	MD Harfor 10e. Street and Number	Abeerdeen 10f. Zip Coda					10g. Citizan of What Country?				
by Funeral I	1536 Perryman Rd 11. Marital Status 1 □ Nevar Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yes 2 ☒ N If Yas, Give Yaar or Datas:		3. Was Dece	ecify Cuba	ispanic Origin? In, Maxicen, Pue Specify:	(Specify Yas or Norto Rican, atc.)	Blac	ce - American li ck, White, etc. y: Black		
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DHMH 16 Rav 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day Month Yeer Louise Rose Chambers July 26, 1998 12:30a.m 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Death Randallstown Baltimore Old Court Nursing Center If Undar 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (Stata or Foreign Country) Months Days 219-34-4727 89 Yrs. April 26, 1909 Va Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County Md. n/a Baltimore TXXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3521 Meadowside Road 21207 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No if Yes, Give Yaar or Datas: 1 ☐ Never Married > Married 1 Yes 2√No Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty 124h Grade Nurse 18. Mothar's Name (First, Middle, Maiden Sumema) unknown 17. Father's Neme (First, Middle, Last) Ernest Lipscomb Rose 19a. informant's Name/Relationship (Type, Print) Husband 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Leon R. Chambers 3521 Meadowside Road Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cramation 3 ☐ Ramoval from State Woodlawn, Md. Aug. 3 Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Sarvice Licensea nutter 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of) 16 Due to (or as a consequenca of): Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequenca of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 6 Probably 4 Unknown 0 BRUIN 100 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 2 D N 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 28. Placa of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 26d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide

Division of Vital Records, P.O. Box affer 8 The law requires that the signed by 3 Deen page 2 has certificate Physician: 9 funeral

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Certification:

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29a. Certifier

(Check only one)

31. Date filed (Month, Day, JUL 30

Funeral

Director

e than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be Department of Health and Merial Important: If them 27 is marked of

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Physician

/Medical **Examiner**

Maryland 21215-0020

State Registrar

1 Certifying Physicien: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner steted. 29b. Signature and title of certifier

29c. Licanse number

29d. Date signad (Month, Dey, Year)

000 4000

Begistrar's Signature when worder

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death Month Virginia Mae Dugan July 29 1998 12:25 A.M. 4a. Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Mount Airy If Under 1 Yaar If Undar 24 Hrs Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Days Months 1 □ M 2 🖾 F 70 579-54-9690 March 3, 1928 Virginia Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 TXNo Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 101 West Rd. 21771 United States 11. Marital Status 12. Was Decadant Evar in U,S. Armad Forcas? Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, White, etc. 1 Navar Married 2 Marriad 1 ☐ Yas 21 No If Yas, Giva Yaar or Datas: 1 Yas 2X No Specify: Spacify: White 3 ☐Widowad 4 ☐ Divorced 15. Decedant's Education (Spacify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) 11th Homemaker Own Household 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) William Edward Satterwhite Melissa May Whitaker 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 101 West Rd. Mount Airy, MD 21771 Dete 20c. Lo Linda Poole (daughter) 20a. Method of Disposition 20b. Place of Disposition (Nama of cametery, cremetory or othar placa) 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) True Gospel Jul 31, 1998 Lisbon, MD 21. Signature of Fungsal Se 22. Name and Addrass of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Pert1. Enter the disaasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final diseasa or condition rasulting in daath) Two Years 20 Due to (or as a consequenca of) Due to (or as a consequenca of) Due to (or es e consequança of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Wes an autopsy 24b. Wara autopsy findings avallabla prior to complation of cause of death? 2 2 No 1 ☐ Yas 1 ☐ Yas 25 No 26. Placa of Daath (Check only one)

Physician /Medical Examiner

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Physician

/Medical

Examiner

Director

Funeral

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show

Peges 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mentel Hygiene.
ant: If Item 27 is marked other than "netural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exprener must be notified at

Baltimore, Maryland 21215-0020

the Maryland

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or Attending Physicien: director. this funeral

Division of Vital Records, P.O. Box 68

To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun

State Registrar

Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Diseese or injury that initiated avants rasulting in daath) Lest Pert II. Other algorificant conditions confributing to death but not resulting in the underlying cause given in Part I. ð Completed 25. Wes casa refarred to madical axaminar?

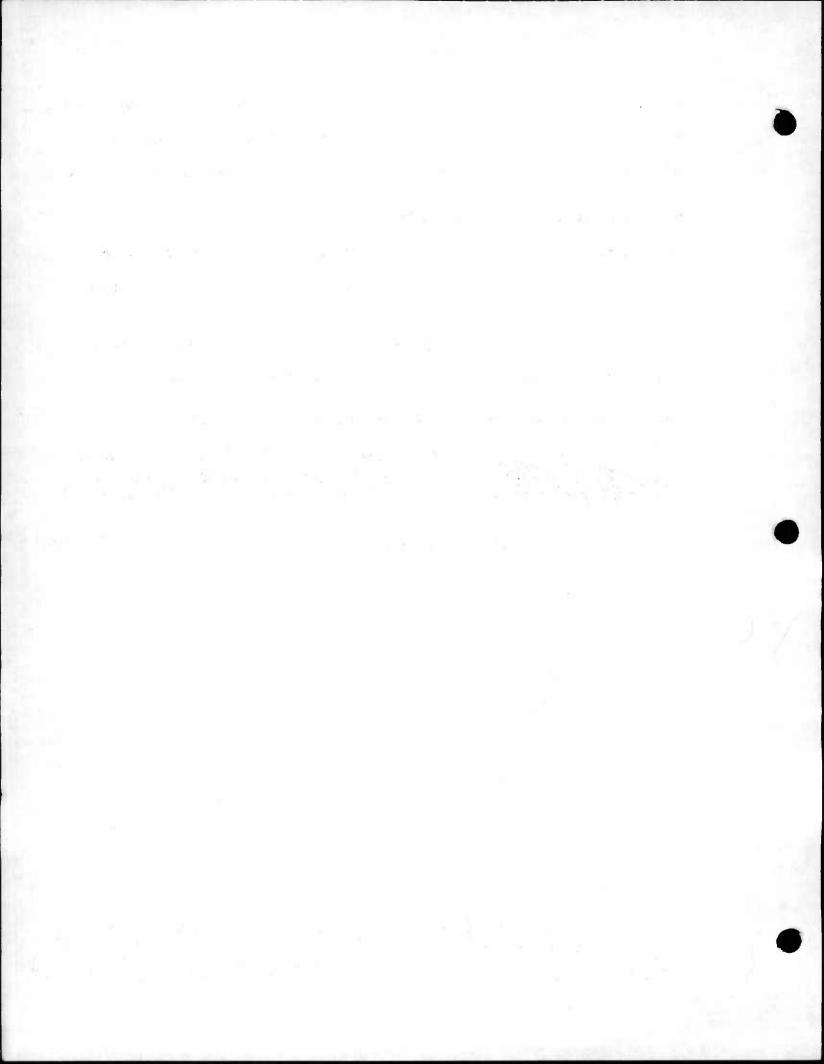
1 Yes 2 No Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Deta of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 2 Accidant 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28a. Plece of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 THomicida Medicai 29a. Certifier cartifying Phyaician: To the best of my knowledge, death occurred at the time, deta and place, and due to the ceuse(s) end menner es steted (Check only one) Modical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year

31. Data

30. Name and address of person who comple

32. pegistrar's Signature

ed causa of death (Itam 23a) (Type, Print



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Deeth 3. Time of Death 1. Decedant's Neme (First, Middle, Last) Month 27 Edward George 4c. County of Death Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Baltimore City Harbor HOS nter le s. Date of Birth (Month, Dey, Year) 9. Birthplese (State or Foreign Country) Mary Land If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Deys 10M 20 F Months 70 Yrs. 215-24-7666 Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10e. Stete 10b. County 1 ☐ Yes 2 1 No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 386 Cork Rd. 21061 United States Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 💆 Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) Elementery/Sacondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Sumeme) Erwin H. Davis Katherine Kurtz 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Veronica B. Moyer / Daughter 386 Cork Rd., Glen Burnie, Maryland 21061 20b. Piece of Disposition (Nama of cemetery, crematory or other plece) Deta 20c. Location - City or Town, State 20a Method of Disposition July 30 1 ₺ Burial 2 Cremation 3 Removel from State Glen Haven Mem. Pk. 4 □ □Opation 5 □ Othar (Specify) 1998 Glen Burnie, Maryland gral Se OFF os Licenses 22. Nama and Addrass of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., GLen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition rasulting in daeth) Dua to (or as a consequence of): Ischemia Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disaese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) oronam Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 1 | Yee 2 No 3 | Probably 4 | Unknown 24b. Wara eutopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy 2 No 1 ☐ Yes 2 No 1 Yas 26. Placa of Death (Chack only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatiant 2 ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 28b. Time of

Division of Vital Records, P.O. Box 68768 signed by to certificata has t lirector, page 2 s Physician: funeral director, Aftar this Attending death. after death filled in by

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

item 27 is marked other than "neturel", or items 23s or 28e-1 show other traumstic event, the Machael Examiner must be notified at

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filed within 72 hours after thygiana.

permit. Pages 1 and 2 should be filled bapartment of Haalth and Mantal Hygis important: If Item 27 is marked other?

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Certification: To

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3 Suicida

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altimore, Maryland 21215-0020

death with the Maryland

25. Wes case referred to medical Yes 2□ No 28e. Dete of Injury (Month, Dey Year) 27. Mannar of Deeth 28c. Injury et Work? 5 Panding Investigation Naturel 2 Accident

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Certifying Physician: To tha best of my knowledge, death occurred et tha tima, date end placa, end dua to the ceuse(s) end mannar as statad.

| Medical Examiner: On the bests of examination and/or investigetion, in my opinion, daeth occurred et the time, data and place, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature and titla of certifier 29c. Licanse number

Julia Davidson-Randall

M.D

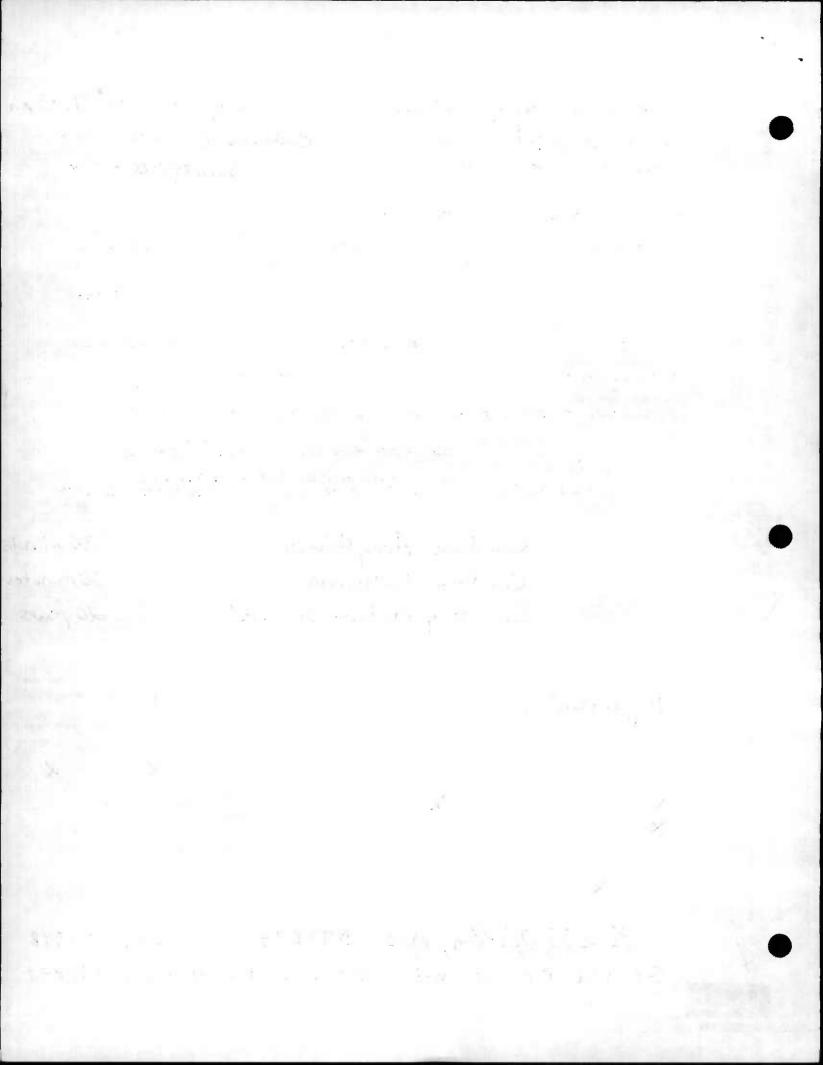
6 Could not be determined

30. Neme end eddress of person who complated cause of deeth (Item 23a) (Type, Print)

Hanover Street South 3001 M.D DOLLON Year) 31. Data filed (Month, Day, 32. Registra s Signature

State Registrar

To the Hospital within 24 hours a To the Funeral C



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #19a Per Anatomy Bord, 29d Per MD Film G761 7-30-98RC 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** hevenne /Medical City Town, or Location of Death County of Death 4a Facility Neme If not institution, give street end number 4c. **Examiner** If Under 24 Hrs. 9. Birthplece (Stete or Fereign If Under 1 Year 8. Date of Birth (Month, Dey, MAY 2 5. Sociaf Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Hours none Director Usual Residence of Decedent deeth with the Marylend th end Mental hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinat must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? unknown Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritaf Status permit. Pages 1 and 2 should be filed within 72 hours effer coppartment of Health end Mental Hygiene. Important: if Item 27 Is marked other than "natural", or iten any injury or other traumatic event, trained one. Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify 2 3 ☐ Widowed 4 ☐ Divorced IACH Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LNIA 18 Mother's Name (First, Middle, Meiden Surneme): 17. Father's Name (First, Middle, Last) Be ARCUS 19a., Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Nymber, City or Town, Stete, Zip Code) 2516 @Davis/Mother 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Ronald Wade, Director Baltimore, Maryland 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner certificate be executed pue buriel-trar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien for use es the burie P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequenca of): The law requires that the deeth ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown s been signed be should be dete Records, þ 24b. Were autopsy findings eveileble prior to completion of causa of death? 24a. Was an autopsy Completed page 2 hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificete Division of Vital Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) ^oL 200No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Neturef fniury 5 Pending To the Funeral Director: Aft To the Funeral Director: Aft 1 Yes investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homleide 0 1 Carillying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. edical 29e Certifier 29d. Date signed (Month, Dev. Year) 29b. Signature and title of cartifier 29c License number 2

ath (Item 23a) (Type, Print)

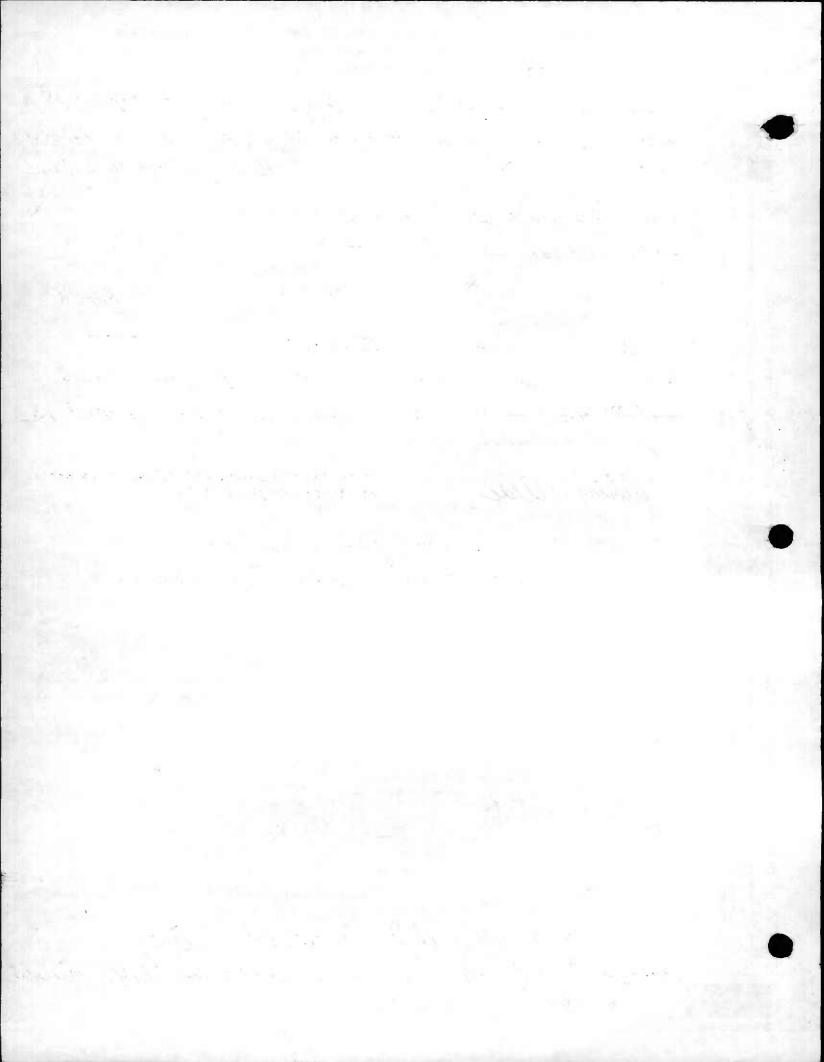
32. Registrar's Signature

3, 1998

State Registrar 30. Name and address of person who completed cause

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 23238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day **Physician** July 26, 1998
4b. City, Town, or Location of Deeth 4c. County FLORINE MAE WEST EHLERS 10:25 AM /Medical 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore County

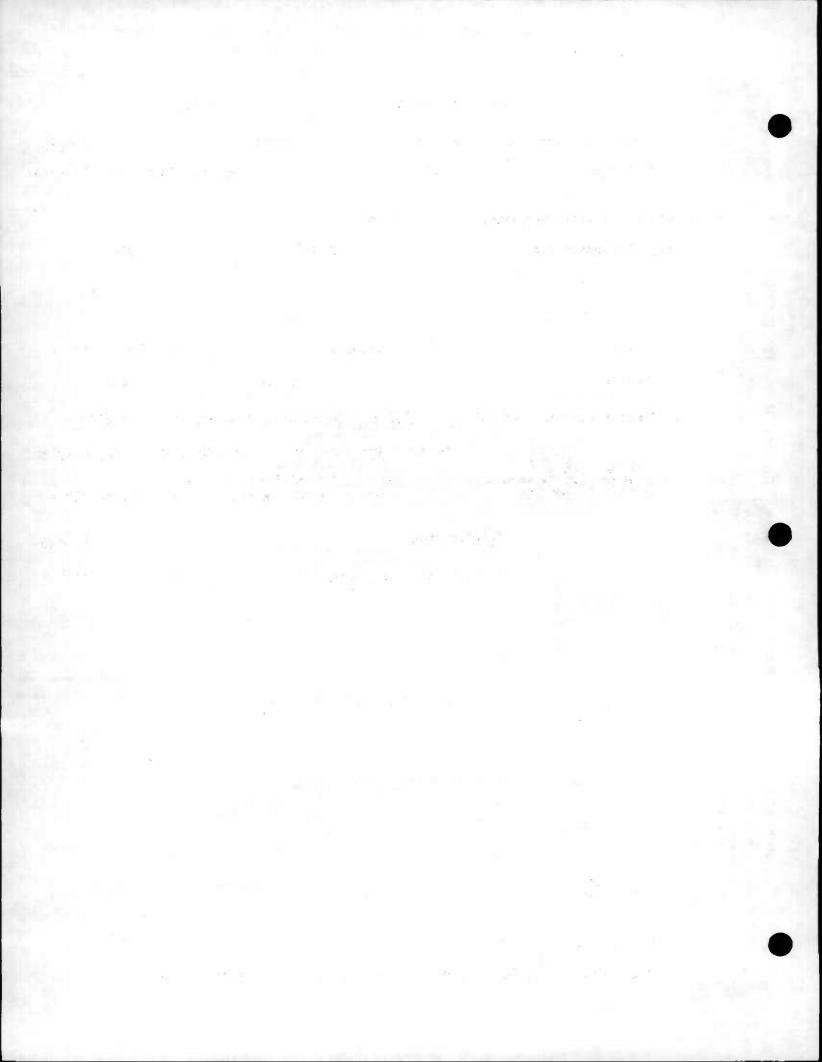
9. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** 1 ☐ M 2 🖸 F Days Yrs. Director 219-22-9101 Dec 14, 1922 West Virginia Usuel Residenca of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show with Injury or other traumatic event, the Mexical Examinet must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10e. State 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore County Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1118 Stevenson Lane 21286 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2X No If Yes, Give Year or Detes: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 th Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Frederick West 10 Sadie Belle 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place)

1118 Stevenson Lane, Towson, Maryland 21204
20c. Location - City or Town, State J. Kenneth Ehlers, Husband altimore, 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Druid Ridge Cemetery 7/29/98 Pikesville, Maryland 21. Signatura of Funeral Service Lichney

Martin D. Lawson 22. Name end Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 00 York Road, Baltimore, MD 21212 the mode of dying, such as cardiac or respiretory errest. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feiture. List only one cause on each line. Interval Between Onset end Deeth **Physician** () Nemonia /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 6878 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Partial Removal of Lung 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ð 24b. Were autopsy tindings evailable prior to 24e. Wes en autopsy Completed completion of cause of death? page 2 s 1□ Yes 2 No 1 □ Yes 2 □ No or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funarai 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Certification: After 5 Pending investigation 1 ☑ Neturel 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide The prifying Phyalctan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2. The dicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50760 Were M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Weng, M.D., 660 Kenilworth Avenue, Towson, Maryland 21204 31. Date filed (Month, Day, Year) State Registrar 3 0 1998

DHMH 16 Rev 6/95



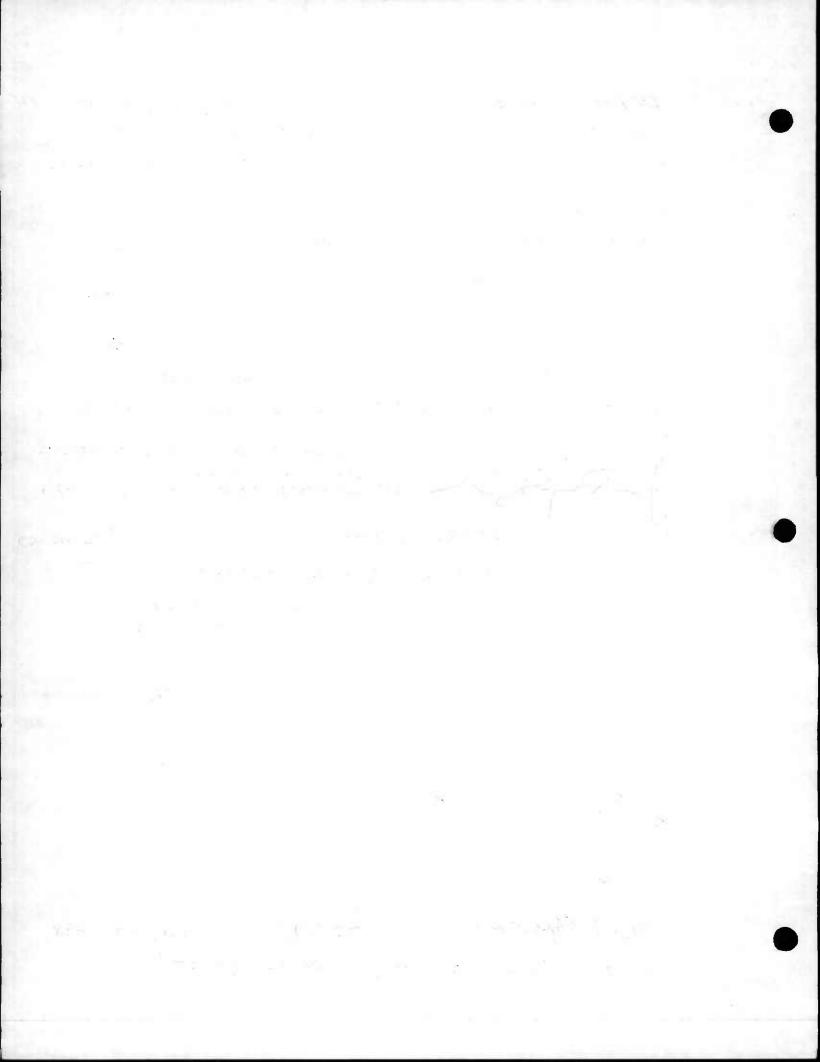
State of Maryland / Department of Health and Mental Hygiene 🔾 🌣 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** DEAN 10:32 PH PREELS 23, 1998 /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Bon Secour Hospital Baltimore n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept 6, 1969 | 9. Birthplace (State or F Month) | Sept 6, 1969 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 219 84 6820 1 √ M 2 □ F 28/rs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral', or items 23e or 28a-f sh Examiner must be notified Directo Maryland Baltimore 1 ☐ Yes 2 ☐ No Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? e filed within 72 hours efter death with at Hygiene.
other than "natural", or items 23e or? 45 "C" Glenwood Road 21221 USA Funeral natural', or items 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced r than 'natural 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None is 1 and 2 should be filed in if Health and Mental Hygie Item 27 is marked other in other traumatic event, III Saltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Samuel B. Freels Wanda Brown 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 45 "C" Glenwood Road Essex, Maryland 21221 Wanda I. Freels (mother) permit. Peges 1 end Department of Health Important: if Item 27 any Injury or other tr 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 7/29/98 Balto. Co. Maryland 22. Name end Address of Fecility Bruzdzinski Funeral Home PA sture of Funeral Service Licens 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final diseese or condition resulting in deeth) HYPERKALEMIA /Medical Z HOURS **Examiner** Due to (or es a consequence of): Physician/Medical Examiner END-STAGE RENAL DISEASE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): The law requires thet the death certificeteche age P.O. Box 68760, END-STAGE ACQUIRED IMMUNODEFICIENCY Due to (or es e consequence of): SYNDROM E Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should be 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 🗆 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ R/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this the funeral 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Division 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital C 24 hours e Funeral D Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical 29b. Signeture and title of certifies

Edward Solgran or Mio 29c. License number 29d. Date signed (Month, Dey, Year) July 27, 1998 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 2000 W BALTIMORE ST BOLGIANO MO EDWARD

State Registrar

32 Amistres Signature Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath **Physician** Nargare 4b. City, Town, or Location of Daeth 1998 4c. County of Deeth /Medical 11:59 P.M 4e. Fecility Neme (If not institution, give streat end number) **Examiner** GENESIS ELDERCARE-HOMEWOOD CENTER Baltimore 8. Date of Birth (Month, Dey, Yaer) 5. Social Security Number If Under 1 If Under 24 Hrs. 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2♥ F Months Hours Director 215-10-8690 July 17, 1914 Maryland Usuel Residance of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f ahow of other than "natural", or items 23a or 28a-f show event, the Medical Examiner regard be nothing at Maryland N/A Director 1) Yes 2 □ No Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5803 Stuart Avenue 21215 Funeral USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or iter any injury or other traumetic event, the Medical Examines once. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 Nidowed 4 □ Divorced White Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Maxmillian Felix Carl Pawlik Johanna Witzgall 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Numbar, City or Town, State, Zip Code) Eileen C. Weis (Daughter) 5803 Stuart Avenue, Baltimore, Maryland 21215 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) Baltimore Maryland 21215 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) Green Mount Crematory 22. Name end Address of Fecility 7/29/98 Baltimore, Maryland 21. Signature of Funeral Servine Li Martin ausor Mitchell-Wiedefeld Home, Inc. Martin'D. Lawson 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as perdiad or respiratory arrest, Mary 1 and 2 1 perby mate shock, or heart failure. List only one ceuse on each line. Physician Onset end Deeth Immediate Causa (Final diseese or condition rasulting in death) /Medical SEPTICAFMIA Examiner Due to (or es e consequence of): Physician/Medical Examiner BRAIN ABSCESS Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseesa or InJury that Intleted events resulting In deeth) Lest Dua to (or as e consequence of) Records, P.O. Box 68760 Due to (or es e consequence of) The lew requires thet the death cer Pert ff. Other significant conditione contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PHEUMONIA ð director, page 2 should Be Completed 24b. Were eutopsy findings evelleble prior fo completion of ceuse of deeth? 24a. Wes en eutopsy performed? HYDERTEMSION COMERSTIVE HEART FAILURE certificate 1 ☐ Yes 2 ☐ No Division of Vital l or Attanding Physician: 25. Was case referred to medical axaminer? 26. Place of Deeth (Chack only one) Hospitel: 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA To the Hospital to many within 24 hours effer death. To the Funeral Director: After this of homeletely filled in by the funeral directors. 1 ☐ Yes 2 ☐ No Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the bast of my knowledge, daeth occurred et the time, data and plece, end dua to the cause(s) end mennar es statad. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et tha tima, data end place, end due to the ceuse(s) end menner stated. 29a. Cartifier Medical (Check only one)

29c. License number

0 47945

2007 E. Mosthern Parkway Baltimore MD Z1214

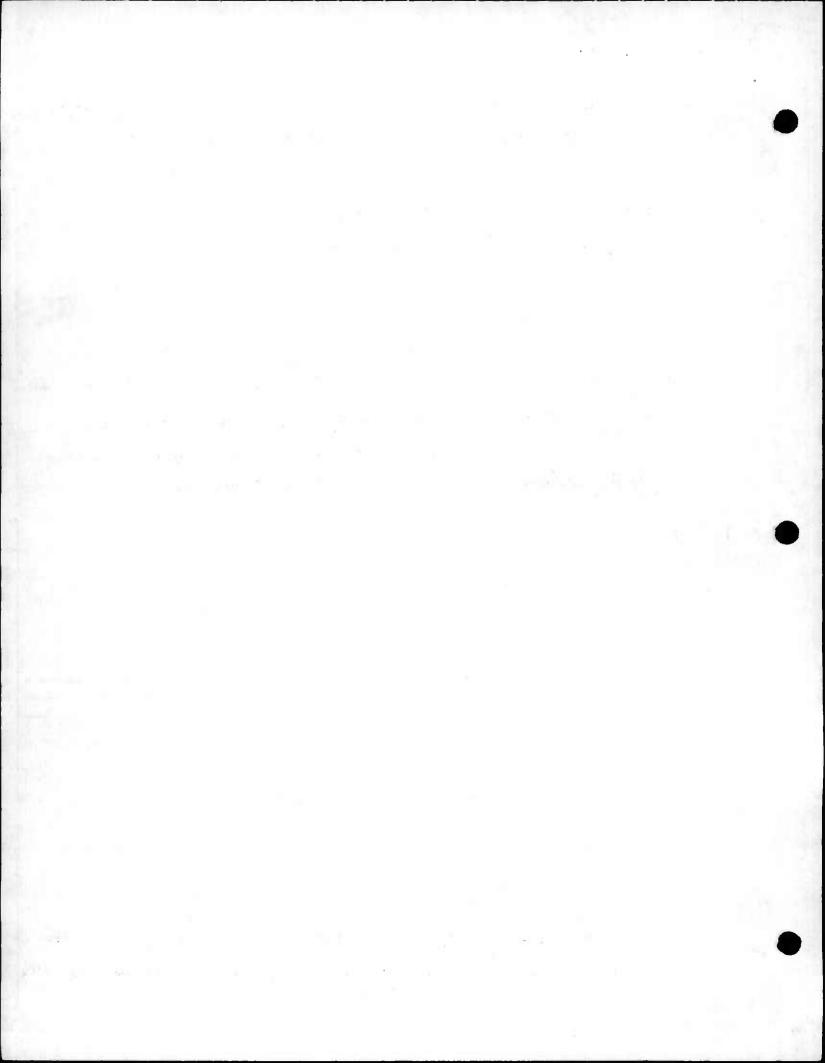
29d. Dete signed (Month, Dey, Yeer)

State Registrar 29b. Signeture end titla of certifier

30. Nema and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

and Signature

ALEEM, MD



State of Maryland / Department of Health and Mental Hygiene

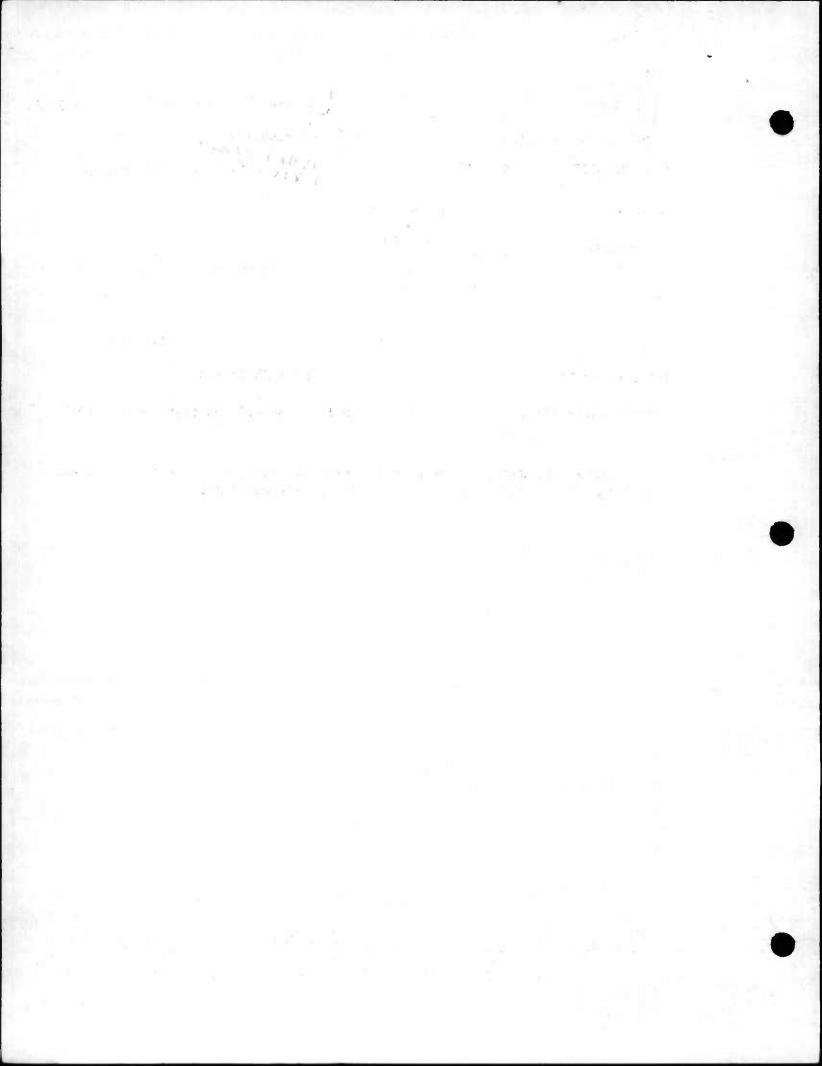
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					Ce	rtificat	e of	Death		Reg.	No.		
Physician /Medical	ı	Decedent's Neme (First, Middle, FRANCES	Last)		FRE	EMAN			2. Dete of Month		Dey	Year	3. Time of Dee
Examiner	- 12	e. Fecility Neme (If not Institution, LEVINDALE	give street end n	umber)				4b. City, Town BALTI			4c. County	of Deeth	
uneral irector		212-10-7381	5. Sex 1 □ M 2 ☑ F		. last birthdey) 79 Yrs.	If Under Months	Deys		Hrs. 8. Dete of (Month, AUG	Birth Dey, Yea 16,1	ar) 1918	9. Birthple Countr OHIO	ce (State or Fo
notified at	1	Jsuel Residence of Decedent Oe. Stete 10b. County MARYLAND BA	LTIMORE	10c. C	ity, Town or Lo	ocation	<u> </u>					100	d. Inside City Lin
	1	0e. Street end Number 8 STONEHENGE CI	DOLE IN	ודת 5		10f. Zip	Code	21208		10g.		Whet Countr	y?
ir, or items 23s		1. Meritel Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Dec	cedent Ever In torces?		Wes Decedif Yes, special		Hispenic Origin ban, Mexican, F	? (Specify Yes or Puerto Rican, etc.)	No-		ce - America ck, White, et	c.
		15. Decedent's	Education		16e. Dece	dent's Usua	el Occi	upation e during most of	l wadving	16b	. Kind of B	usiness/Indu	
then the Men		Elementery/Secondary (0-12)		(1-4or 5+)	life.	LESWO	se retir	ed)	Working		CLOTI	TNC	
aumatic avant, the Medical summitic avant, the Medical To Be Completed	1	7. Fether's Neme (First, Middle, Li HARRY	est)	BLUMI		THOW	N. IV-II.	18. Mother's	Name (First, Midd	- 1		ne)	AEL
7 is marked of traumatic averaged To Be		19e. Informent's Neme/Reletionshi	p (Type, Print)		19b. Maili	ng Address	s (Stree	et end Number d	or Rural Route Nur	nber, Cit	ty or Town	State, Zip C	Code)
If item 27 is or other tra	2	MR. BRUCE ABRA	MSON (SO	206	Dince of Diene	neition (Ala	me of		NIT 5 BA	7		21208 City or Tow	
Y Or		1 ☐ Burlei 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		Stete	BNAI	ISRAE	other pl	(ece)	7-28-199			DRE, M	
Important: any injury once.	1	21. Signeture of Funerel Service Li	Li rom	ann	More	2	SOL		ON & BROS				D 21208
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# - F	2	7. Menner of Deeth Neturel 5 Pending	28a. Dete (Mor	of Injury oth, Dey Year)	28b. Time o Injury		8c. inju		ng Home 5 ☐ Re 28d. Descrit				
		2 ☐ Accident investiga	the										
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and Director: After the fulled in by the funeral in Certification:	L	3 Sulcide 4 Homicide 6 Could no determin 29e. Certifier (Check only one) Could no determin	t be 28e. Plece build Physician: To the saminer: On the b	ing, etc. (Speci	ify) owledge, deetl	h occurred	et the t	time, dete end p	28f. Location City or	own, St	e(s) end me	enner es sta	ted.
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	MD Film G761 7-30-98R0 1. Decedant's Nama (First, Middla, Les		Cer	rtment of F	Death		g. No.	lina V from	
Physician	Ida Cilbert	51)				Month July 9,	Day	Yaar	50 AM
/Medical Examiner	4a. Facility Nama (If not Institution, give	a street and number)	1 21		4b. City, Town, or Lo		4c. County of		JO AII
LAGIIIIICI	5502 Harris Far	m Lane			Clarksvil	lle	How		
Funeral	5. Social Sacurity Number 6. S		last birthday)	If Under 1 Yaer Months Days	if Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpleca (Sta Country)	ata or Foraig
Director	Usual Residence of Decedant	□M 25kF 85	Yrs.			Dec. 6,	1912	Russia	
A ==	10e. Steta 10b. County	10c. C	ity, Town or Loc	cation				10d. insid	la City Limit
tor to	Maryland Howard	C	larksvi	11e				10	Yes 2 N
or 28a-f s be notified Director	10e. Street and Number			10f. Zip Coda		11	0g. Citizan of W	/hat Country?	
rai l	5502 Harris Farm			21029			U.S.A.		
natural; or items 23a or 28a-f show deal Examiner must be notified at eted by Funeral Director	11. Marital Stetus 1 Nevar Married 2 Merried 3 Widowed 4 Divorced	12. Was Dacedant Evar in I Armed Forcas? 1 Yas 2 No if Yes, Give Yaar or Datas:	if	Vas Decedant of H Yas, specify Cub	dispanic Origin? (Spen, Maxican, Puarto Specify:	ecify Yas or No- Rican, atc.)		e - Amarican india k, Whita, atc. White	n,
"natural", ideal Exe	15. Decedant's Ed	ucetion	16a. Deced	ant's Usual Occup	pation		16b. Kind of Bus		
	(Specify only highast gra	Coilege (1-4or 5+)	(Giva lifa. L	kind of work dona OO NOT usa retired Homemake	oation during most of work d)	ing	Own I	Home	
atic event	17. Fathar's Nama (First, Middla, Last) Isidore Barsky				18. Mothar's Name Lena She	a (First, Middla, M Linkman	Aaidan Sumama	a)	
important: If item 27 is marked other than any injury or other traumatic event, the M once. To Be Comp	19a. Informant's Name/Ralationship (7 Dennis Gilbert/				and Number or Run. / Court,				5
ury or oth	20e. Mathod of Disposition 1 ☐ Buriai 2 ☐ Crametion 3 ☐ 4 ☒ Donation 5 ☐ Other (Spacify	Ramovai from Stete	Piace of Dispos cematary, cram	sition (Nama of natory or other pla	ce)	Data	20c. Location - (City or Town, Stat	a
importi any inj once.	21. Signature of Funds al Service Lices	Wade, Direc			Soffee Board Maryland		Baltin	more Stre	eet
d by the attending physician and algorithms for use as the buriel-transit appropriate the standard of the stan	immediata Causa (Final disaasa or condition rasuiting in death) Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaasa or injury thet initiated avants rasuiting in daath) Last	b. OCNERS Dua to (or as a consequence or a consequence or a consequence or a consequence or a consequenc	uance of):	Infercts	sis		yea.	year re
gned by the attendin be datached for usa by Physician/N	Pert ii. Other significant conditions co	entributing to death but not ra-	suiting in the un	darlying ceusa giv	van in Part I.	23b. Did to	bacco uae con	tribute to the cau	se of deat
d by that date of Phy	Periphent	ertinel o	clus	re dise	et e	1 🗆 Ye	s 2□No	3 Probably	4 🗌 Unkno
should should eted	Generon	or foot		1 013		24a. Was ar	n autopsy ned?	24b. Wara autor available pr completion of death?	for to
page 2						1 ☐ Ye	s 2 No	1 🗆 Yes	2 No
Be Be	25. Was cesa rafarred to medical axaminar?				26. Placa of Deat	n (Check only on	a)		
thar this inaral di on: To	1 Yas 20 No 27. Magmar of Death 1 Natural 5 Panding 2 Accident invastigation	28a. Data of injury (Month, Day Year)	28b. Tima of Injury	28c. injur Wor	4 LI Nursing Ho	ma 5 Rasida 28d. Describe ho			
within 24 hours after death. To the Funeral Director: After tomplately filled in by the funeral Medical Certification:	3 Suicide 6 Could not be datarmined		oma, farm, stra fy)			28f. Location (St. City or Town	raat and Numbe , Stata)	er or Rural Routa I	Vum <i>ber</i> ,
thin 24 hours the Funera mplataly fille Medical C	29a. Certifiar (Check only one)	vsicien: To the best of my knotiner: On the basis of examination end mannar stated.	owledga, daath ation and/or inv	occurred at tha tir astigation, in my o	ma, data and place, opinion, daath occurr	and dua to the ca ed at tha tima, da	usa(s) and mar ata and piace, a	nnar as stated. Ind dua to tha cau	se(s)
	DOL Classification of a service			29c. Licans	e number	25	d. Pata signed	(Month, Day, Yes	ar)
To the comple	29b. Signeture and title of certifiar				-		100		
To the comple	290. Signaturand titleyor certifiar	in has		1)0	Drive Co		July 1	3 1998	

DHMH 16 Ray 6/95



Charles Gilmore

				Cer	tificat	e of L	Death			Reg. No.) (_	3243
cian	1. Decedent's Nama (First, Mic	idia, Last)							2. Data of De Month	eth Day	Yaar	3. Tima of Death
lical -	Charles		one							6, 1998		4:35 P.M.
iner	4a Facility Nama (If not institut					4		WII, OF LO	cation of Daath			
	643 HILLVIEW 5. Social Security Number	KUAD.	(HOME)	. last birthday)	If Undar	1 Year	If Undar			N/A		aca (Stata or Foraign
	437-03-5098	1 ∑ M 2□ F	82	Yrs.	Months	Days	Hours	Min.	8. Data of Birt (Month, Da JUNE 8	,1916	MONRO	Ĕ, LA.
-	Usual Rasidanca of Dacedant 10a. Stata 10b. Coun	thu .	100.0	ity Town or Lo	nation						10	d looks City I lmits
7.1		ity		ity, Town or Lo							10	d. Inside City Limits 1
ec ec	MARYLAND 10e. Street and Number		В	ALTIMOR	10f. Zip	Code				10g. Citizen of	What Count	٨
0	643 HILLVIEW	RUAD				1225				USA	-61	
Funeral Director	11. Marital Status		cedant Evar In	J,S. 13. V			ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		ca - Amarica	
교	1 Nevar Marriad 2 M	arried 1 √ Yes	2 No		□ Yas		Spacify:	i, ruano	riican, otc./	Specif		
d by	3 Widowad 4 Divorce	ad Yaar or	Datas:								AFRU	.AMERICAN
Completed	(Specify only high	ant's Education hast grada complated		16a. Deced (Give	ent's Usua kind of wo DO NOT u	al Occupi ork dona d se ratired	ation du <i>ring</i> m <i>osi</i> f)	t of worki	ing	16b. Kind of E	usinass/indi	ustry
mo I	Elamentary/Secondary (0-12) Cotlega	(1-4or 5+)		K -				- 100	MERCHA	ANT SE	AMAN
Bec	17. Father's Nema (First, Middl	la, Last)					18. Motha	ır's Nama	(First, Middle,	Maidan Sumai	ma)	
10	MARION (GILMORE					MA	RY	GILMOR	RE		
	19a. Informant's Name/Ralatio									er, City or Town		
	CALLIE GILN 20a. Mathod of Disposition	MORE WIFE	20b	Placa of Dispo			RUAD,	BAL	Data Data	MARYLA 20c. Location		
	1X Burial 2 Cramation		Stata	camatary, cran	natory or o	ther plac		1				
.	4 ☐ Donation 5 ☐ Othar 21. Signature of Funeral Service	,	A	RBUTUS			PK.		/29/98	ARBUTUS	, MAK	YLAND
	LLOYD M	ESTEP		ES	TEP	BROT	HERS	FUNE	RAL HON	E, P.A.	LI BAID	01017
	23a. Part1. Entar the disaasa,	or complications that	caused the dea							RE, MARY		ZIZI/ Approximata Interval Between
	shock, or haart failura. L	ist only ona causa on	aach lina.			1					i	Interval Between Onsat and Death
	Immediata Causa (Final disaasa or condition	Re	Spine	House	K	31	une					minutes
	resulting in death)	a.	Due to	(or as a conseq	uance of):							
Examiner		b. 198	OHE									yeiges
Exar	Sequantially list conditions, if any, laading to immediata		Dua to	(or as a consaq	uance of):						t	
dicail	Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Diseasa or Injury that initiated avants	c	Due to (or as a conseq	iance of):							
0	rasulting in death) Last		Dua to (or as a conseq	Jan 100 017.						t	
Physician/Me		d		- 1165							1	
sici	Part It. Other significant condi	itions contributing to	daath but not ra	sulting In tha ur	ndarlying o	ausa giv	an In Part I		23b. Dld	lobacco usa co	ontribute to	the cause of death?
F.	CLL								1 🗆	Yas 20 No	3 Prob	abiy 4 Unknown
Be Completed by									24a Was	an autopsy	24b. We	ra autopsy findings
ete									perfe	rmad?	eva	ilabla prior to oplation of cause laath?
dwc									10	vas ANN		Yes 2□No
Ö	25. Was casa rafarrad to medi	cal					26 Place	of Death	(Chack only		,,,	7103 2010
ToB	examinar?	Hospital:	Inpatiant 2	☐ ER/Outpatien	t 3 🗆 DC	Oth	or.	ursing Ho	Λ.	danca 6 □Ot	her (Specify)
:uc	27. Mannar of Death 12 Natural 5 ☐ Pane		a of tnjury nth, Day Year)	28b. Time of Injury	2	28c. Injun Worl	y at k?		28d. Dascribe	how Injury occu	rred	
catle	2 Accidant inve	stigation			М		Yas 2□					
E	3 ☐ Sulcide 6 ☐ Couldata	mined 28a. Plac	ca of Injury - At I ding, atc. (Spac	home, farm, stri	eat, factor	y, office			28f. Location (City or To	Straat and Num vn, State)	bar or Rural	Routa Number,
2	29a. Certifier	ring Physician. To th	a bast of much	outodoo dooth		at the tim	sa data an	d place	and due to the	naven(a) and m	annor on et	atad
edical Certification:		ying Physician: To the al Examinar: On the and ma	basis of examin nnar stated.	ation and/or inv	rastigation	, in my of	pinion, daa	th occurr	ed at the tima,	date and place	and dua to	tha causa(s)
	29b. Signatura and title of parti	fior			290	c. Licans	a number			29d. Data sign	ad (Month, E	Day, Year)
	May	Ny A	140			nu	149	VV		JUIN	27	1. 1498
	30 Number and eddress of person	on who completed car	use of death (Ite	om 23a) (Typę,	Print)	V	111	7.7) /	2 11		1
	1700-1104	11/0/10	1/10	12 1V	hon.		-14	2710	101	50 /Ti	0.0.0	M12121
1	31. Date filed (Month, Day, Yas	UUMITE	Ragis ray's Sig	10~1	· Ch	DO	711)	070	17.71	0 1 1 1 1	1010	04/41

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

The second of the ROBERT NA Separate in the second of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23244 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** GERWE 27 SOSEPH 2155 July /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore City Baltimore Center Veterans Administration Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept. 27, 1926 Maryland Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) **Funeral** Months 1€M 2□F 212 20 3956 Yrs. 71 Director Usual Residenca of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Maryland Baltimore Directo Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumetic event, the Medical Examinal must be it 78 West Kingston Park Lane 21220 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: WW T Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Stetus Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced WW II 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Construction 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Frederick Gerwe Sophia Josephine Voigts 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Beuleh Gerwe (Wife) 7 Bladen Rd. Baltimore, Md. 21221 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens Of Faith 7/30/1998 Baltimore, Co. Md. 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md.21221 23e. Parv. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, stock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical ulmonary Examiner Due to (or es e consequence of): Physician/Medical Examiner Congestive Heart Failure Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es-d consequenca of): Pulmonary Disease Chronic Obstructive that initieted events resulting in death) Lest Due to (or es e consequence of): use es signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ should b 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy Completed s certificate hes t director, page 2 s 20 No 1 Yes 1 ☐ Yes 2 ☐ No director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpetient 3 DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 5 4 Homicide

P.O. Box 68760, Division of Vital tal or Attending Physician: T. s after death. 24 hours af Funeral Di etely filled ii Hospital To the Hospi within 24 hou To the Funer completely fil edical

Baltimore, Maryland 21215-0020

State Registrar 29a. Certifier

(Check only one)

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29c. License number

29d. Dete signed (Month, Dey, Year)

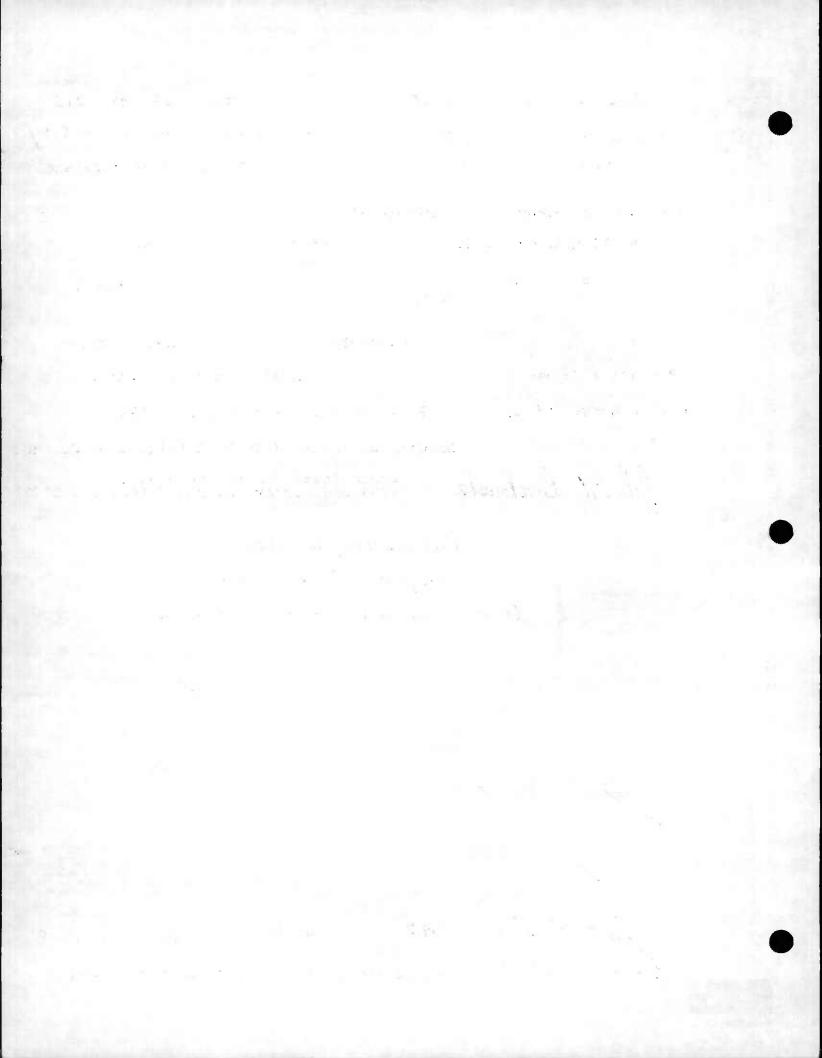
29b. Signeture engititle of certifier Vuma 13-105-60 July 27, 1998

and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

VA Medical Center, 22 N. Greene St. Barto, MD 21201 Verma,

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

LaIit 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

BERTH	A HI	INDE	RSC	N			-	
TEMS:	#23	PART	I.	27	28A-F	PER	MEO	

C752 9-3-09 UP Certificate of Death

23245

	11EMS: #2.	_	AKI 1, 27,28A-F PE			3-98	WK. Ceri	illicate	OI I	Jeani			Reg. No.			
	Physicia: /Medica	n	1. Decedent's Name (First, Midd Bertha Mal	de, Last oin	Hende	erson						Dete of Dee Month JULY 2	Dey	Yeer 3		ne of Deeth
	Examine		4e Fecility Neme (If not institution							b. City, Town, o			4c. Count	y of Deeth		
	Funeral Director	4	2524 WEST FAY 5. Social Security Number 215-24-4020	6. Se			. last birthdey) Yrs.	If Under 1 Months D		BALTIMO If Under 24 Hi Hours Mi		Dete of Birt (Month, De)	h v, Year)			ete or Foreigr
-	D		Usuel Residence of Decedent			.,					1	11-07	-17			
	how		10a. State 10b. Count	У		10c. C	ity, Town or Loc	ation						1		de City Limits
	Ma-f.	000	MD	NA		B	altimo	ore							1 U	Yes 2∐No X
	or 28	Director	10a. Street end Number					10f. Zip Co	ode				10g. Citizen of	Whet Cour	ntry?	
	th w		2524 W. Fave	ett.	e Stree	> t		21:	22	3			USA			
20			2524 W. Faye	rried	1 Tes 2	No No	"	as Deceden Yes, specify	t of H Cube	ispenic Origin? en, Mexican, Pue Specify:	(Sp <i>ec</i> i erto Ri	fy Yes or No- can, etc.)	14. Ra Ble Speci	ca - Americ ck, White,	etc.	n,
8	are!	O D	3X Widowed 4 □ Divorce		Year or Date	is:						1		BI	ack	
Maryland 21215-0020	nati	Completed	15. Decede (Specify only high	nt's Edu est <i>gr</i> ed	cation e co <i>mpleted)</i>		16a. Decede	ent's Usuel C	one	etion du <i>ring</i> most of w f)	orking		16b. Kind of E	Business/Inc	dustry	
12		E	Elementary/Secondary (0-12)		College (1-4	or 5+)				,			Md. D	rvdo	ck (Compa
d 2	other vent, it		4th Grade 17. Fether's Neme (First, Middle	(ast)	NA		L a	bore	2	18. Mother's N	eme /	First Middle		_		
an	0 2 5 6	ă									00 (.	mot, modalo,				
7	should b	2	John 19e. Informent's Neme/Reletion		Abin		10h Mailine	Addross (C	troot	Liza end Number or i	Dural I	Pourto Atumbo	Schu			
Ma	d2s than 7 is r traui															
	1 end Health em 27 ther t		Daisy M. 20e. Method of Disposition	DOI	uglas	20h	2813 Place of Dispos	Ash.	lai	nd Aver	nue	Balt	20c. Location	, Md	· 2	1205
20	Peges 1 er nent of Hea nrt: If Nem 2 iry or other	ı '	UBurial 2 ☐ Cremation	3 □ P	Removel from Sta	ate	cemetery, crem	etory or othe	r pled	,	1	3.502				
=	tmer tant: jury		4 □ Donetion 5 □ Other (Specify)		V	oshell				3 (07-31	-98 D	unda.	IK,	Md.
Baltimore,	permit. Pege Department of important: If eny injury or		21. Signature of Funeral Service	Licens	· Ohn	1-/	22.	Name end A	Addre	ss of Facility	Bal	timor	ce, Ma	ryla	nd :	21202
ш	20539		Manne	200	2011	(00) WM	I.C. 1	Mai	ch FH						
			Part1. Enter the disease, of shock, or heart failure. Lis	or compl	ications thet cau	sed the dee	th. Do not ente	r the mode o	of dyin	g, such es card	ec or	respiretory er	rest, .		Approx	rimete I Between
	Physician		orioni, or more randro.	n orny or	10 04030 011 000									1		end Deeth
(0)	/Medical		Immediate Ceuse (Final disease or condition			SMOKE	INHALATI	ON						1		
	Examiner		resulting In death)		Э	Due to (or es e consequ	uence of):	-							
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	th certificate be executed ending physician and ruse as the bunel-trensit	Examiner	Sequentially list conditions	6	b	Due to (or es e consegu	ience of):						1		
Ć	exec in an nel-tr	Ž	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that injury causes.				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							ŀ		
Box 68760,	e be	200	HIGH HIMMORD GAGING		o	Due to (or as e consequ	ence of):								
89	ificel g phy es th	2	resulting in deeth) Lest			540 10 (01 45 0 00115045	01,00								
XO	ndin	arymedical			d									<u> </u>		
m	B = 0 =		Part II. Other elgnificant condit	lone cor	atributing to deat	h hut not ro	culting in the un	doduing cour	no giv	on in Port I		23h Did	obacco use c	netribute t	o the car	une of death
0	the school	Finysic	Part II. Other eignificant condit	ions cor	itributing to deet	II Dut not re	suiting in the un	gerrying ceus	se giv	en in Pen I.			Yes 2□ No			
0	£ 90											10	Tes 2LINO	3 110	Dabty	4 DE OHKHOW
Vital Records,	been sign	Completed by											en eutopsy rmed?	ev	eileble p	psy findings rior fo n of cause
Re	hes ge 2											-			deeth?	_
a	icate he											180	res 2□No	13	Yes	2 No
Ž	certificate		25. Wes case referred to medic examiner?	_	lospitet:				(A)	26. Plece of D						
of	Pi di		1 Styles 2 No		1 L Inp		ER/Outpetient		Oth	4 Li Nursing			tence 6 Ot		fy)	
Division	After fune	HOLLE	E ED MOOIGOIN	ga	28e. Date of I (Month, 7/25/9		7:00 UNK		Mor 1	yet k? Yes 2 No			VICTIM O		E FIR	RE
Vis	or Attended Brector: In by the		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nof be mined	28e. Plece of building.	Injury - At h	nome, farm, stre	et, factory, o	ffice		28	f. Location (S City or Tox	Street end Num	ber or Rure	el Route	Number,
	s effe in Dir				HON						2		AYETTE S	Т.		

State Registrar

Medicai

29a. Certifier (Check only one)

29b. Signature end title 🖈

31. Dete filed (Month, Day, Year) estance 111 Penn Street, Baltimore, Maryland 21201

cause of death (Item 23a) (Type, Print)

1 Certifying Phyetclen: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

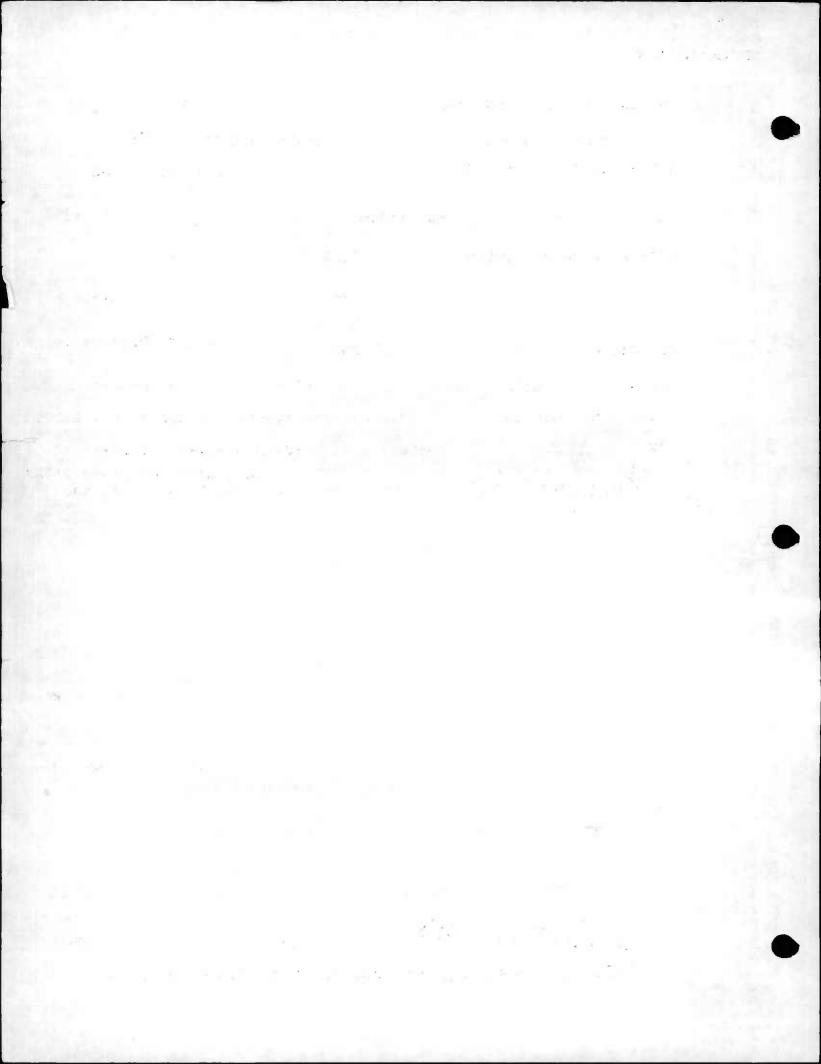
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner steted.

29c. License number

O.C.M.E.

29d. Dete signed (Month, Dey, Yeer)

JULY 26, 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

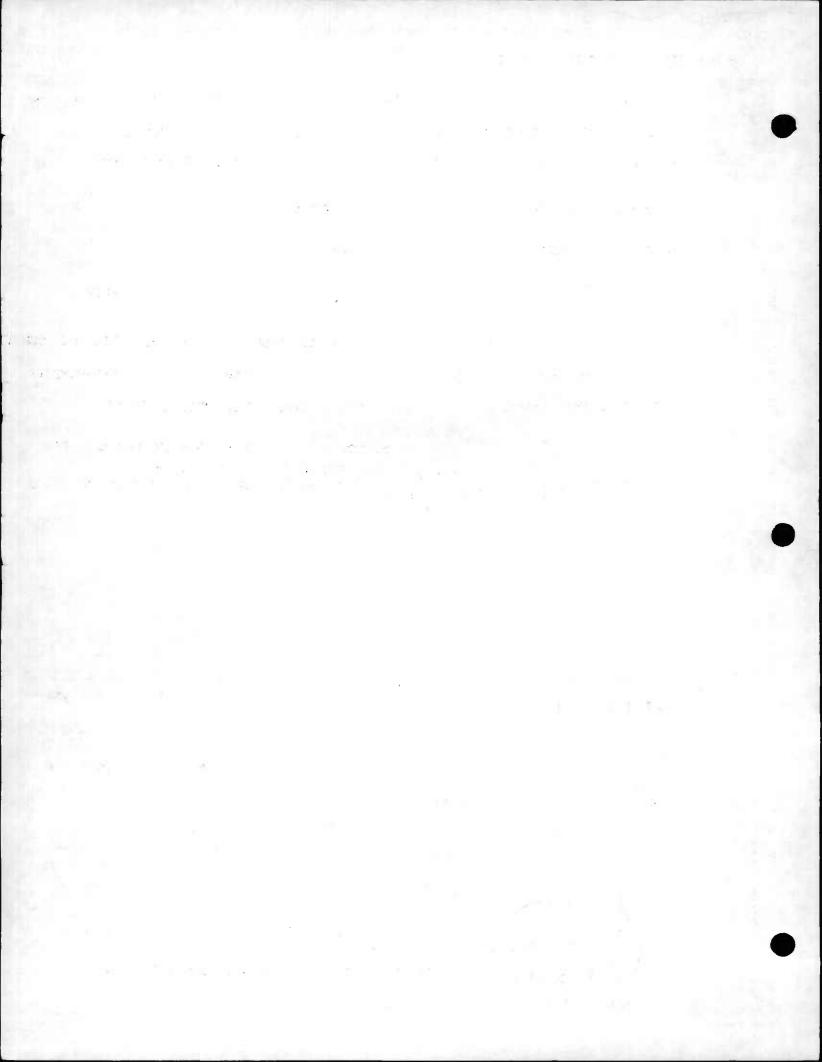
23246

				Certificate of	Dealli		Reg. No.				
Physiciar /Medica	HYMAN		HOL	INSKY	4b. City, Town, or		26, 1998		3. Time of Death 1:25pm		
Examine											
	3601 CLARKS LA 5. Social Security Number		on the use to at hist	hday) If Under 1 Year	BALTIM If Under 24 Hrs		N/		Jana (State or Fernisa		
Funeral	089-10-0697	1 M 2 F	e (In yrs. last birti	Months Dave		(Month, De	y, Yeer)	Cour	place (Stete or Foreign htry)		
Director	Usuel Residence of Decedent		84		1	OCT 20	,1913	NEV	V YORK		
and **	10a. State 10b. Coun	ty	10c. City, Town	or Location				1	0d. Inside City Limits		
ath with the Marylan 23a or 28a-1 show set be notified at	MARYLAND N/A	į.		BALTIM	ORE				1 X Yes 2 □ No		
the h	10e. Street and Number			10f. Zip Code			10g. Citizen of N	What Cour	nto/?		
	3601 CLARKS LA	אוד אוסתי פונג		Toil Zip Code	21215				,		
Hours after death with the Maryland hours after death with the Maryland turel; or items 23s or 28s-f show at Exercitor must be notified at all his conserval Disperse.	SOOT CHARRY II	12. Was Decedent	Ever in It S	12 Was Doordont of I		inacify Vac or No	US 14 Bac		en Indian,		
aftar daa	11. Marital Status	Armed Forces?		13. Was Decedent of I If Yes, specify Cub	an, Mexicen, Puer	to Rican, etc.)	Bla	ck, White,			
urs aff		If Yes Give **	NO	1 ☐ Yes 2 💢 No	Specify:		Specify	v: V	VHITE		
72 hours after dec		ent's Education	160	Decedent's Usual Occu	nation		16b. Kind of B	usiness/in	dustry		
ed within 72 ho ygiene. or then "natural, to the Medical.	(Specify only high	nest grede completed)		(Give kind of work done life. DO NOT use retire	during most of wo	rking	TOD. TUTO OF D	001110001111	acony		
4 12 13-0020 d within 72 hours af giene. pr than "natural", or pr Medical English	Elementary/Secondary (0-12) College (1-4or	5+)	FOREMAN	,		יייטייי	TIE (COMPANY		
		e. Last)		LOMENTAIN	18. Mothar's Na	me (First, Middle			CMPAINI		
and dispersion of the first Half Half Half Half Half Half Half Half		SAMUEL	HOT.	INSKY		FANNY			RAFTSOV		
should be and Menta marked umatic e	19a. Informant's Name/Relatio			Mailing Address (Stree	t and Atomborous B		or City or Town				
2 2 2 2	MRS. SHIRLEY H			601 CLARKS							
		- TOBERDINE (WEEK	•	Disposition (Neme of	DAME! AE	Date	20c. Location				
S = = 0	20a. Method of Disposition ▼ Burial 2 □ Cremation	n 3 □Removal from State	cemeter	y, cremetory or other pla				- City of To	JWII, State		
Pa Pa III	4 □ Donation 5 □ Other	(Specify)	ANSHE	EMUNAH AITZ	CHAIM	7/29/98	BALT	O., 1	1D		
Baltimo permit. Page Department of Important: If any Injury or	21. Signature of Funaral Sarying	e Licensee		22. Name and Addr	ess of Facility	BROS .	, INC.				
n gagga	I ledie h	- XItelbug	N	8900 REIS			PIKESVI	LLE.	MD 21208		
	234 Fart Enter the disease.	or on indications that caused tonly one cause on each li	the death. Do n	1				000/	Approximate Interval Between		
Physician	snock, or neart value. L	at only one cause on each I	ne.						Onset and Death		
/Medical	Immediate Cause (Final	0 -		00-				i			
Examiner	disease or condition resulting in death)	a. CALL	1/te	AKKESY							
		1 - 1	Due to (or as a c	ARRES V consequence of): CTACH							
bet lad		b. VENTI			YCARDI.	4					
oxecuted n and ini-transit	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or es a c	onsequence of):				i			
- B	ceuse. Enter Underlying Cause (Disease or Injury	С						i			
	resulting in death) Last	The second second	Due to (or as a c	onsequence of):							
X S		d.									
ath con								- !			
	Part II. Other significant condi	tions contributing to death b	ut not rasulting in	tha underlying cause g	iven in Part I.	23b. Dld	tobecco use co	ntribute t	o the ceuse of deeth?		
d by the latached	Car	BRETINE	4	CT FAIL	100	10	Yes 2⊞No	3 □ Pro	bably 4 Unknown		
es this	00.	009/10	NEAH					1			
oquir bud		ASTOLIC	11.0	FUNCTIO	1)	24a. Was	an autopsy ormed?	av	ere autopsy findings vailable prior to		
The law requir	21	AZIBLIC	17 471	PUNCITO	~			CC	ompletion of causa death?		
The law ata has paga 2						1□	Yes 2 No	11	□Yes 2□ No		
vician: The certificata rector, pag		nal			OC Place of De						
Physician: rthis certific rtal director,		Hospital:			hor	ath (Check only		- (0	4)		
Physic this c ral dire		1 ☐ Inpati	-	patient 3L DOA	4 Li Nursing	lome 5 Resi	how injury occur		ry)		
ding B. After funer	1 ☑Naturel 5 ☐ Pend		y Yeer) Ir	njury Wo	ork?]Yes 2 □ No	200. 0000100	now injury cood				
Attending or death.	2 Accident Invest	d not be	441 4-			294 Location	Ctroot and Alum	har or Pur	al Route Number,		
DIVISION OF VITAL RECORDS, tall or Attending Physician: The law requires the start death. Solution of the this certificate has been signified in by the funeral director, paga 2 should be to extification. To Be Compided by	4 ☐ Homicide dete	mined 286. Place of in building, el	c. (Specify)	m, street, factory, office			wn, Stete)	Der Or Har	ar rigule reumber,		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	/										
To the Hospital within 24 hours To the Funeral completaly filled	29a. Certifier 1 Certify (Check only 2 Medic	ring Physician: To the best at Examiner: On the basis o									
To the Ho within 24 To the Fu completal		and manuary st	ated.								
To the To the common	29b. Signature and title of certi	0///	1	29c. Licen	se number		29d. Date signe	ed (Month,	Dey, Yeer)		
	1 190011	und leek	11	D	22115		7/27	198			
K	30. Name and address of person	on who completed cause of	leath (Item 23a) (Type, Print)			2 -				
2	BEKHARD	RUBIN, A		8680 LIB	EKTY &	20 6	ANDALLS	TO CON	10 2/138		
State	31. Date filed (Month, Day, Yea	39. Regist	ar's Signature					,			
Registra	1111 3 117	998 Julian	avidson-Ra	ndell							

Registrar

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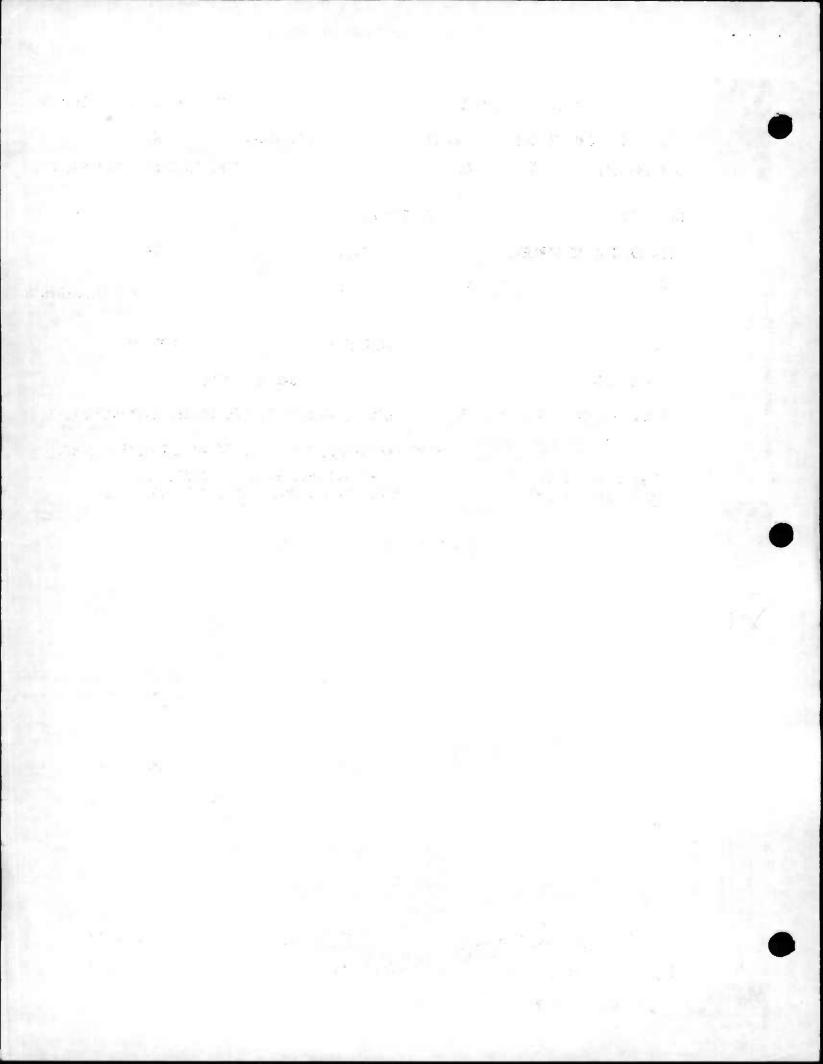
TIENS:	11 63	PART I, 27, 28A-F PÉR N 1. Decedent's Name (First, Middle, Las		-31-98	wr. 007		01	Death	2. Dete of				Ime of Deeth
	sician edical	JACOB			HA	AS			JULY JULY	25, Dey	1998 [°]		531 PM
	miner	4a Fecility Neme (If not institution, give HOWARD COUNTY C			AL			4b. City, Town, COLUM	or Location of De		County of D		
Fune Direc		5. Sociel Security Number 6. S 577–66–2483	ex	Age (in yrs.	lest birthday). 8 Yrs.	If Und	er 1 Year S Days	If Under 24 Hours		Birth Day 9 (1)	9. 949 I	Birthplece (S	Stete or Foreign
pu .		Usuel Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Loc	cation						10d Inc	side City Limits
Maryla febo	5	MARYLAND HOWA	ARD	100. 0	, , , out, or 200	ALIOTI	COLU	MBIA					¥Yes 2□ No
the 1	rect	10e. Street end Number				10f. 2	ip Code	-		10g. Citla	zen of Whet	Country?	
th with	a D	10177 GOODIN CIRC	CLE				21046	5			USA		
be filed within 72 hours after death with the Maryland ntal Hygiene. The context has "natural", or items 23s or 28s-1 show with the context has not a second to the context has not a second	by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Date	es? □ X No	If	Yes, sp	edent of Hoecify Cuba 2 No	dispanic Origin an, Mexicen, P Specify:	? (Specify Yes or verto Rican, etc.)			merican Ind /hite, etc. WHITE	ien,
5-0 72 ho	Be Completed	15. Decedent's Ed (Specify only highest gre			16a. Deced	ent's Us	uel Occup	etion during most of	working	16b. Kir	nd of Busine	ess/Industry	
Vithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. D	O NOT	use retired	ATTORN	. 2	TAME	ז ג זאכוי	REVEN	UE SERV
d 2 filled v Hygie ther t	ပိ	17. Fether's Name (First, Middle, Lest)	4				IAV		Name (First, Mide			I/T: A LTIA	OE DEK
C 0 = 0 5	To Be	JOSEPH	H	HAA	S				DORA			MERME	LSTEIN
Me 2 sulth ar lith ar 27 is		19a. Informant's Neme/Reletionship (1 MRS. JOANN HAAS	Type, Print) (WIFE)						F Rurel Route Nur E COLUMB)
Saltimore, permit. Pages 1 at Department of Heal mportant: if Itam.		20a. Method of Disposition			Plece of Dispos			ce)	Dete	20c. Lo	cation - City	or Town, St	ete
Page ment ant: if		1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specify		ate	MT.				7-29-1	998 SI	PRINGE	FIELD,	PA
Dermii Depar Impor	DUCe.	21. Signature of Funerel Service Licen	Kevins	on	eller	8	900 I	REISTER	ON & BRO	AD BAI		RE, MD	21208
Physicia /Medic Examin	er	23a. Par1. Enter the diseese, or come shock, or heart failure. List only of the diseese or condition resulting in death)		MONOXI	DE INTOX or es e conseq								rel Between t end Death
J, executed in and intransit	dical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or es a consequ	uence o	f):						
LOX 68 /6U, death certificate be executed e attending physician and of or use as the bunel-transit		Cause (Diseese or injury that initieted events resulting In death) Last	C	Due to (d	or es e consequ	ience o	·):						
ath cert	Physician/M		d									1	
. 0 0 2	/sici	Pert II. Other algnificent conditions co	ontributing to deat	h but not res	sulting in the un	derlying	ceuse giv	ven in Pert I.	23b. D	ld tobecco	uea contrib	ute to the c	auea of death?
IS, P.O. Tes that the designed by the a	by Phy	ACUTE INNER EAR DISC	ORDER					البروان	1	☐ Yes 2	□ No 3□	Probably	480nknown
require should	ieted									es en autoperformed?	sy 24	available	on of ceuse
The The page	Соп								111	Yes 2	□ No	Yes	2□ No
Of VITAL Physician: Tribis certificat	Be	25. Wes case referred to medicel exeminer?	Hospitel:				Oth		Deeth (Check on	ly one)			
Physic ral dir	. To	1 XXes 2 No 27. Manner of Deeth	1 LJ Inp		XER/Outpetlent 28b. Time of	3 🗆 I		4 LI NUISI	ng Home 5 ☐ Re 28d. Descrit			Specify)	
ding th.	ition	1 ☐ Neturel 5 ☐ Pending investigation	28e. Dete of I (Month, 7-25-98	Day Yeer)	3:00	M	28c. Injur Wor	rk? Yes 2 X ☐No				FXHAIIS	T FUMES
LIVISION OF VITAL HER IN A THEORY OF THE STATE OF THE ST	Certification:	6 ☐ Could not be determined	28e. Plece of building, IN CAR	Injury - At h etc. (Special IN GARA	ome, farm, stre fy) GE/HOME	et, fact	ory, office		28f. Locetion City or		10177 G	r Rural Rout	e Number,
To the Hospital or within 24 hours effe to the Funeral Dir completely filled in	edicai 0	29a. Certifier 1 CertifyIng Phy (Check only one) 2 Medical Example	inar: On the basis	s of exemine					lece, end due to t	he ceuse(s)	end menne	r es steted.	
	Med	29b. Signature and title of certifier	end menner	stated.		2	9c. Licens	e number		29d Date	e signed (M	lonth, Day, Y	'ear)
o the			1				00	A. T.		1000			
To the Hospital of within 24 hours of To the Funeral D completely filled in			/				0.0	.M.E		JU	LY 2	6, 199	98
To the within 2 To the comple	=1	30. Name and address of person was	completed cause of						imore, Ma			0.52	18



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					Ce	rtifica	te of	Death			Reg. No.			
	1. Decedent's Neme (First, A	fiddle, Last))							2. Date of De		Voor	3. Time of Dear	th
sician	WILBUR	BOYER	J	OHNSON						JULY	23, 1998	Yeer 3	3:15 P.	Μ.
dical niner	4e Fecility Neme (If not instit	ution, give						4b. City, To	wn, or Lo	cation of Deet	4c. County	of Deeth		
Intel	516 EAST 43R	n STDI	FFT	(HOM	E)			BALT	IMORE	-	N/A			
	5. Social Security Number	6. Sex	(rs. lest birthday		r 1 Year	If Under	24 Hrs.	8. Dete of Bir (Month, De		9. Birthp	lece (State or For	e <i>lg</i> n
	578-14-0642	15	M 2□ F	78	Yrs.	Months	Deys	Hours	Min.	SEPT 1	5,1919	HOW	ÄRD, CO.	
	Usuel Residence of Deceder	it												
	10e. Stete 10b. Co	unty		10c.	City, Town or L	ocation						1	0d. Inside City Lin	
tor	MARYLAND				BALTIN	ORE							1 X □ Yes 2□	No
Director	10e. Street end Number		-				p Code				10g. Citizen of	Whet Cour	ntry?	
	516 EAST 43R	n STRI	FFT			213	212				USA			
Funeral	11. Maritel Status		12. Wes Dec	edent Ever in	1 U,S. 13.	Was Dece	dent of F	lispenic Or	igin? (Spe	ecify Yes or No	- 14. Rac	e - Americ		
	1 Never Married 2□	Married	Armed Fo	2 No						Rican, etc.)		ck, White,		
1	3 ☐ Widowed 4 ☐ Divo	rced	If Yes, Gi Year or D			1 🗆 Yes	2/ No	Specify:	1.7		Specif	AFRO	.AMERICA	N
9	15. Dece	dent's Educ	cetion		16e. Dece	dent's Usu	el Occur	ation			16b. Kind of B	usiness/In	dustry	
ble	(Specify only h Elementary/Secondary (0-	1	College (life.	DO NOT	ise retire	during mos d)	it of work	mg				
Completed	10	,	Conego (. 10. 01,	H	IANDYI	MAN				ODD J	OB		
Bec	17. Fether's Neme (First, Mic	ldle, Last)						18. Moth	er's Neme	e (First, Middle	, Meiden Sumen	ne)		
0	UNKNOWN							SA	RAH	BOYER				
-	19a. Informent's Neme/Rele	ionship (Ty	pe, Print)		19b. Mail	ing Addres	s (Street	end Numb	er or Run	al Route Numb	er, City or Town	Stete, Zip	Code)	
	HELEN A. WA	SHING	TON SI	STER	516 F	AST .	43RD	STRE	FT. F	BALTIMO	RE, MAR	YI AND	21212	
	20a. Method of Disposition	0112110	1011 01		. Place of Disp	osition (Ne	me of			Dete	20c. Location			
	1 Burial 2 CCremet		lemovel from	State	cemetery, cre				-	7/2//08	CATONS	VILLE	MD	
	21. Signeture of Funeral Ser		90	1,	2	2 Neme e	nd Addre	ess of Fecili	ity				, I'IU.	
	LLQYD M.	ESTE	P.		ES	STEP I	3ROT	HERS	FUNE	RAL SER	VICE, P.	Α.		
	Allery 1	n.th	1								E, MD.	21217		
	23a. 1. Enter the isees shock, or he rt failure.	e, or compli List only or	ications that one couse on o	eaused the de each line.	eeth. Do not er	nter the mo	de of dyl	ng, such es	cardiec	or respiretory e	errest,		Approximate Intervel Between Onset end Deatl	
н					1 /			,				t I	Oriset end Death	•
	Immediate Ceuse (Finel disease or condition			Dro	25+A+	e	(awc	.eR			1		
	resulting in death)			7 Due to	o (or es e conse	quence of):							19
ne														
Examiner	Sequentially list conditions, if eny, leeding to immediate			Due to	o (or es e conse	quence of	:							
	ceuse. Enter Underlying Ceuse (Disease or injury													
edical	that initieted events resulting in death) Lest	1.	3	Due to	o (or es e conse	quence of)	:			1 1				
Med														
			1									1		
Physician	Pert II. Other significant cor	ditions con	tributing to d	eeth but not	resulting In the	underlying	ceuse gi	ven in Pert	I.	23b. Dld	tobacco use co	ontribute t	o the cause of de	ath?
h										10	Yes 20 No	3 ☐ Pro	babiy 4 Unk	nown
by F														
B										24e. Wes	en eutopsy	24b. W	ere eutopsy findin	gs
et										реп	ormed?	CO	mpletion of ceuse deeth?	
Completed										40	V			
										10		11	☐ Yes 2☐ No	
Be	25. Was cese referred to me examiner?	_	fospitel:				O	hor:		h (Check only				
To	1 Yes 2 No		10		ER/Outpatie		OA	4 LI N	ursing Ho		idence 6 Otl		fy)	
ion	27. Manner of Deeth 1 Meleturel 5 □ Pe		(Mor	of Injury oth, Dey Year	28b. Time Injury		28c. Inju Wo		INIO	204 Describe	how Injury occu	1184		
cat	PLI ACCIDENT	vestigation ould not be	25			М		Yes 2	1140	004 1	(Carent and the	has as D	al Bauta M t	1
T	4 Homicide	termined	28e. Plece build	e of Injury - A ing, etc. (Spe	it home, ferm, s ec <i>ify)</i>	treet, fecto	ry, office				(Street end Num wn, Stete)	ver or Hun	el Route Number,	
edical Certification:														
cal	(Check only 2 Med										ceuse(s) end m			
9	one)	TOUT CAUTING	end mer	ner steted.			,	-piiiioii, 00	000011					
Σ	29b. Signature end title of ce	rtifier				25	c. Licen	se number			29d. Date sign		Day, Year)	
	Xarriel	B	sit.	he			039	9946			7-2	4-9	8	
	30. Name and address of pe	rson who co	impleted cau	se of teath (Item 23a) (Type	, Print)	1	0						
	DAVIE E		bena		400 Ki	rK 1	AUC	, B	1/40.	MO,				
to	31. Date filed (Month, Day,)			Registrer's SI		/200	•	, ,						
tate trar	uu 2	0 100	R d	Sin No	iday Ba	delle								
-	400,72. 41	W 16.		The same of the same of	A THURSDAY F. L.									

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

23249

★Yes 2 No

Approximate Interval Between Onset end Death

2. Date of Death 3. Time of Death Day 1998 JULY 26, 23:55 PM James H. Kyle /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHURCH HOSPITAL BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours Months VA

Funeral Director

8 how the Maryla r than "natural", or items 23s or 25s-f shorthe Medical Examiner must be notified at

hours after flied within 72 al Hygiene. permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked of ò

Maryland 21215-0020

Baltimore.

Physician /Medical Examiner

Examiner Physician/Medical P.O. signed by Records. p should I Completed irector, page 2 Division of Vital director, Be this funeral Certification: i or Attending after death. Director: Aft in by

1∏M 2□F 218-36-4518 56 11-14-41 Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10d, Inside City Limits 10b. County Md NA Baltimore Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 336 S. Spring Court 21202 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yea or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Black À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Laborer various trades 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Kyle Magril Allen 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21202 Edna Mae Kyle 501 E. Preston Street Apt. #417 Balto, MD. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmount Cemetery 07-30-98 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility Funeral Service Licenses Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue west. 23a. Part1. Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel EXSANGUINATION COMPLICATING ARTERIOVENOUS SHUNT ABSCESS disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death?

SEPSIS; NARCOTIC AND COCAINE INTOXICATION

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1)X Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 1 Natural 10:59 Investigation 2 Accident

7-26-98 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred SUBJECT FOUND BLEEDING FROM SHUNT

2 No

24a. Was en eutopsy

26. Place of Deeth (Check only one)

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 336 S. SPRING ST., BALTIMORE MD

HOME To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner ea steted.

Medical Examiner: On the basia of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signuty d title of certifier 29c. License number OCME

d address of person who complete cause of death (Item 23e) (Type, Print) LON Locke, M

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifie.

Medical

State

Registrar

4 Homicide

3 0 1998

32. Registrar's Signeture chia Davidson

DHMH 16 Rev 6/95

Hospital

To the Hosp within 24 ho To the Fune completely f

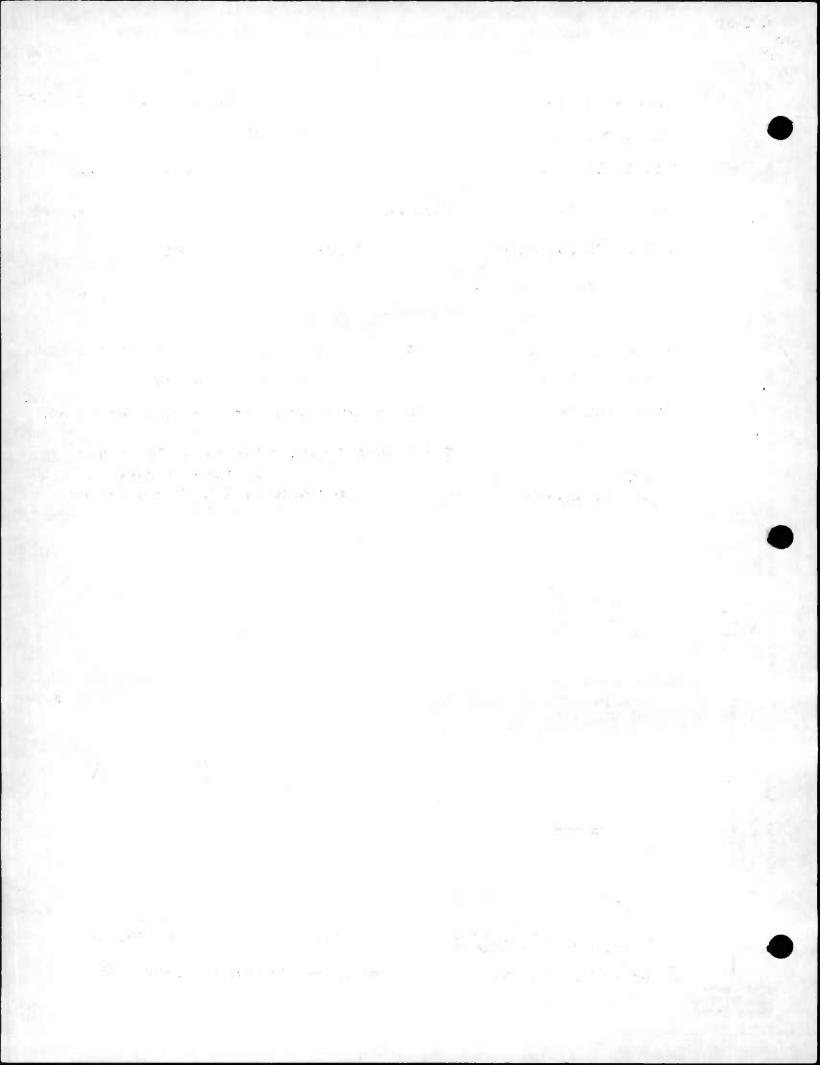
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown

24b. Were autopsy findings evailable prior to completion of ceuse of death?

Yes 2 No

29d. Date signed (Month, Dey, Year)

JULY 27, 1998



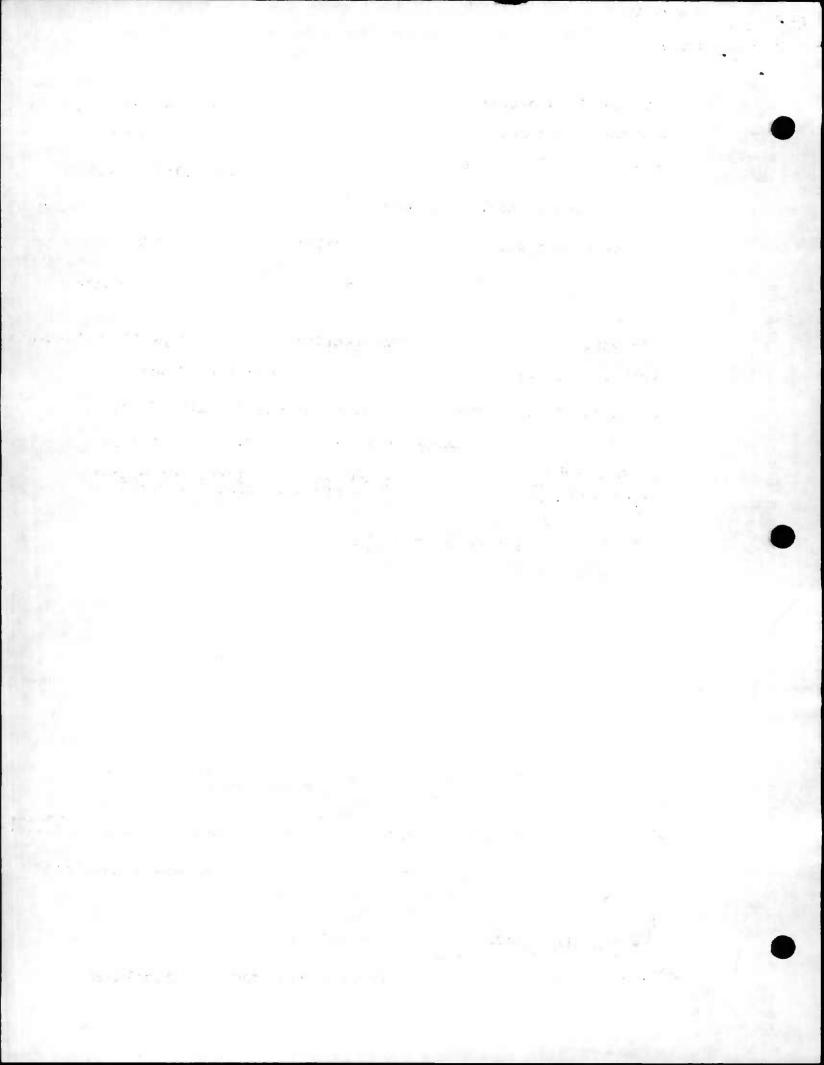
crn Michael A. Kintsler

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State of Maryland / Department of Health and Mental Hygiene	J	U	

Ĺ		d Daniel Market and Artists	41	Cen	tificate of	Death		Reg. No.		3. Time of Deeth
	Physician	1. Decedent's Name (First, Middle, Las Michael A. K					2. Dete of Dee Month	Dey	Yeer	
L	/Medical	4e Fecility Neme (If not institution, give				4b. City, Town, o	July or Location of Death	28] 4c. County	998 of Deeth	5:30 A.M.
	Examiner	North Arundel Hos						Anne		del
	Funeral	5. Social Security Number 6. Se	W.,		If Under 1 Year Months Deys			h (, Yeer)	9. Birthple	ece (Stete or Foreign
	Director	220-70-1563	XM 2□F 39	Yrs.			Aug.25	,1958		land
1	} } =	Usuel Residence of Decedent 10e. Stete 10b. County		ty, Town or Loc	ation				10	d. Inside City Limits
	Fresh fred tor	Md. Anne	Arundel	Severn	l.					1 ☐ Yes 2X No
4	or 284 e not	10e. Street end Number			10f. Zip Code	1 4 4		10g. Citizen of V USA		ry?
-	23a vistb	7709 Twin Oak				144				
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DIVISION OF	within 24 hours effect death, within 24 hours effect death, To the Funeral Director: Atter completely filled in by the funer Medical Certification:	3 Suicide 6 Could not be determined	building, etc. (Special Company) raician: To the best of my knot liner; On the basis of exemine	wledge, deeth	estigetion, In my	ime, dete end ple opinion, deeth oo se number	RT170 ece, end due to the eccurred et the time,	ceuse(s) end me	enner es ste end due to	eted. the ceuse(s)
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State Registrar



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month HOAM EVANS F. KROW July 29 4b. City, Town, or Location of Deeth 4e Fecllity Neme (If not institution, give street end number) 4c. County of Deeth Northwest Hospital Center Randallstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUE - 24 1923 5. Social Security Number 196–16–7800 9. Birthpiece (Stete or Foreign Maryland 6. Sex 1 M 2 □ F 7. Age (In yrs. lest birthday) 74 Yrs. Usuel Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location Md. Baltimore 1 ☐ Yes 2 No Owings Mills 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21117 135 Wengate Road U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Aves 2 No If Yes, Give WW II Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bakery Baker 11 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) John Krout Alice Almoney 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 135 Wengate Rd., Owings Mills, Md. 21117 Ilse Krout 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) Maryland Veterans Cem. July 31, 1998 Owings Mills, Md. 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) Neumonia anknows Due to (or es e consequence of) un/(nos N Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of Due to (or es e consequence of) Unknowd Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24e. Wes en eutopsy 2/2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☑ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

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item 27 is marked other than "natural", or items 23s or 28s-f sho other traumetic event, if a Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, it a Medical Exambles mass.

Baltimore, Maryland 21215-0020

with the Maryland

Bigned be de page 2

certificate 938 Affac or Attending

Division of Vital Records, P.O. Box

Physician/Medical Aq Completed Be 10

after death. Director: An 24 hours a Funeral C

Certification:

Medical

To the I

State Registrar

27. Manner of Deeth 1 Naturel

2 Accident 3 Suicide 4 Homicide

29a. Certifier

29b. Signature

(Check only

5 Pending investigation

6 Could not be determined

1 Inpatient

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 15 milying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

caminer: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

29d. Dete signed (Month, Dey, Yeer)

who completed ceuse of death (Item 23a) (Type, Print) 30. Neme end eddress of pa Ter 5401 ald Court Roud. RANDall Jown MO21/33

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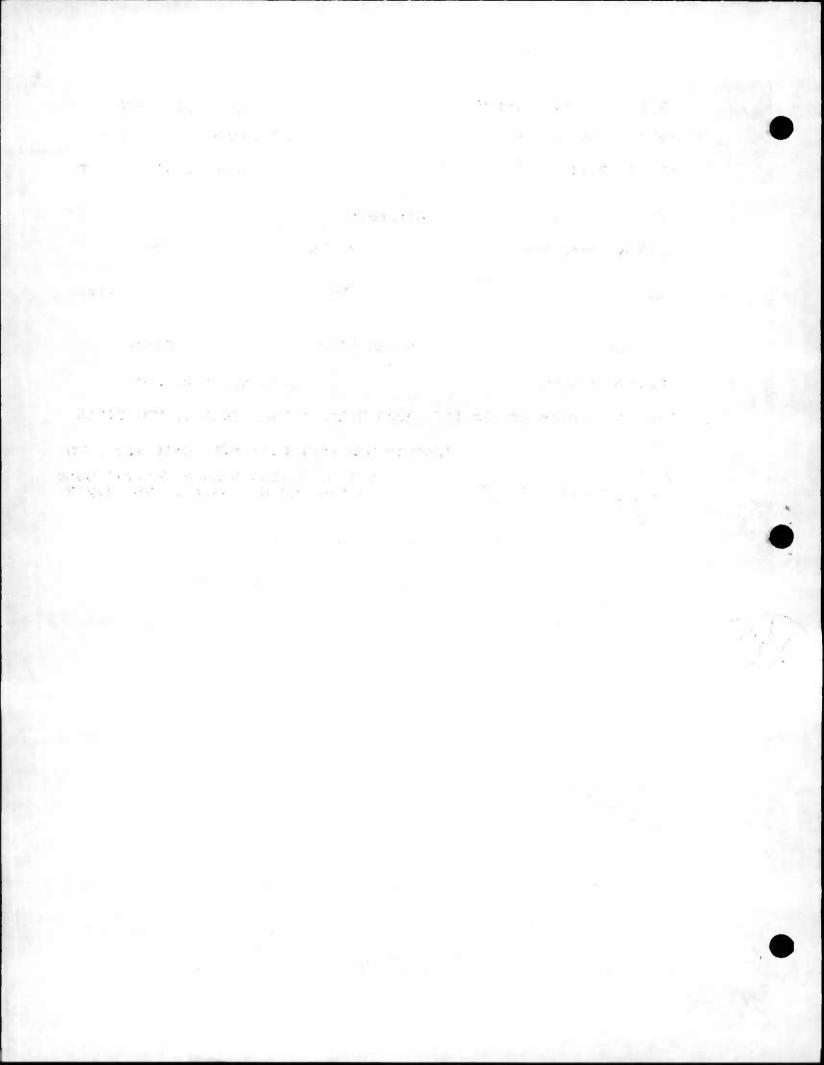
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Year **Physician** Agnes B. Leonard July 28, 1998 unk. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore n/a Belmont Ave. If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months. 1 M XXF 85 Yrs. 219-20-9138 Sept.2,1912 MD Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Director 28a-f n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Hygiene. Wher then "netural", or items 23s or ent, the Medical Examiner must be 21216 USA 3023 Belmont Ave. Funeral Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes CENo Specify: Specify: Black þ 3 DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupetion filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Sales 12th is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permil. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve 2 Robert Beacon Agnes Ethel Bowser 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Shelley Curley/grandchild 3023 Belmont Ave. Balto., MD 21216 20b. Placa of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date XXBurial 2 ☐ Cremetion 3 ☐ Removel from State Arbutus Memorial Park 8/3 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility

James A. Morton & Sons Funeral Home of Funerel Service Licensee 238 Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, show or heart feiture. List only one cause on each line. 1701 Laurens St. Balto., MD Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. that the perfection 1 Yes 2 No 3 Probably 4 Unknown 6 signed d be de þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy page 2 1 Yes 2 No 1 Yes 2 No certificate Physician: 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No This 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affier 1 HNaturel 5 Pending Attending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) or A 4 Homicide 24 hours at Funeral D letely filled i 29a. Certifier tertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medicai (Check only one) 2 Madical Examiner: On the basis of examination end/or Investigetion, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Within 2 To the P 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 0 00 D26748 Stul apelou 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) BALTOMD 4419 UBEROL FALLSRO egistrer's Signature State

DHMH 16 Rev 6/95

Registrar

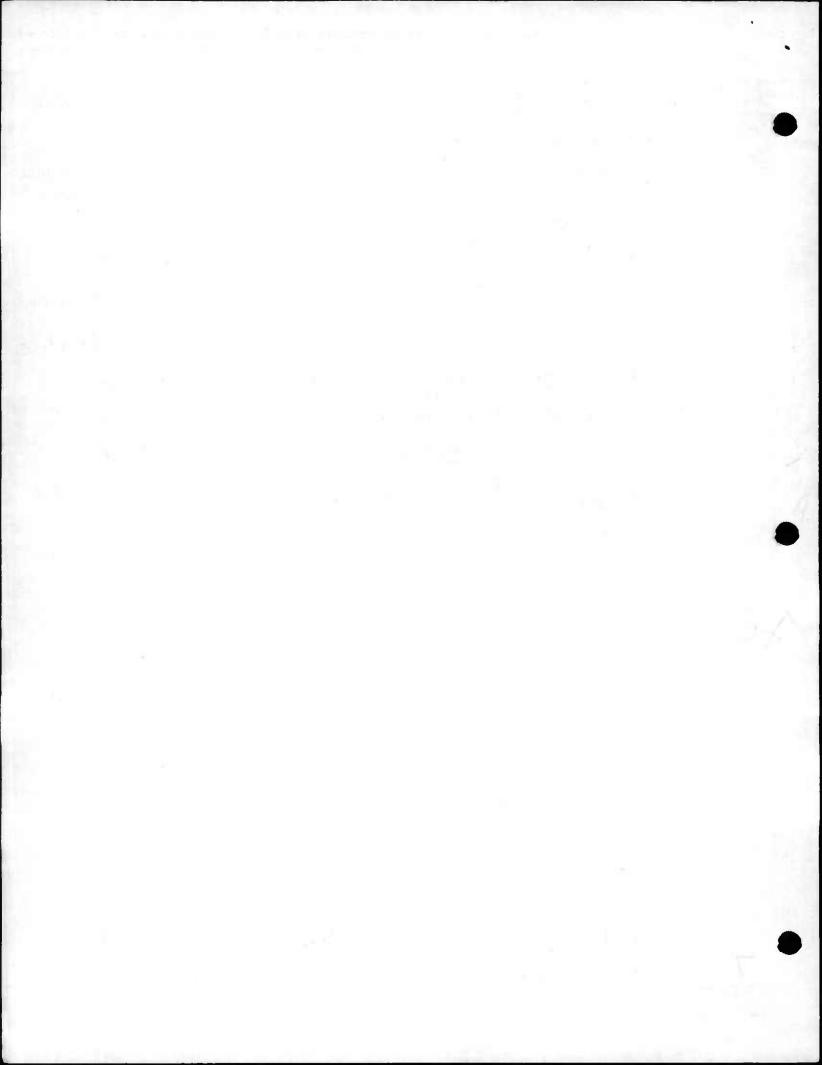


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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.	
Dharatatan	1. Decedent's Name (First, Middle, Last)	2. Dete of Death Month Dey	3. Time of Death
hysician /Medical	Kosie Lee	July 27	1998 135 A
aminer	4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or	Location of Deeth 4c.	County of Deeth
	Maryland General Hospital Baltimon	re Citu	NIA
	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs	8. Dete of Birth	9. Birthplece (Stete or Fore
	212-24-9000 10 M 2/0 F 88 Yrs. Months Deys Hours Min.	Feb 10 191	10 South Carali
	Usuel Residence of Decedent	100.10,111	Joseph Carolli
١.	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Llm
Š	Maryland NIA Baltimore		1 XYes 2 □
Directo	10e. Street end Number 10f. Zip Code	10g. Citi;	zen of Whet Country?
	13025 Hanlon Avenue 21216		11 <a< td=""></a<>
Funeral	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (S	Specify Yes or No-	14. Race - American Indien,
Fu	1 Never Married 2 Married 1 Yes 2 No	to Rican, etc.)	Bleck, White, etc.
þ	3 Wildowed 4 □ Divorced If Yes, Give 1 □ Yes 2 □ No Specify:	1	Brocity: America
Completed	15. Decedent's Education 16a. Decedent's Usuel Occupation	16b. Kir	nd of Business/Industry
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O	17. Fether's Neme (First, Middle, Last)	me (First, Middle, Meiden	Sumame)
To Be	William Honry Houds Wicto	ria / 1	Williams
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	Mar C 1 T (3/3/4) 202/ 1-1	APT. DI	11 2 12 17
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	1 Burial 2 Cremetion 3 Removal from State	7/2 1/0 c/ D	cation - City or Town, Stete
	4 Donation 5 Other (Specify) Baltimore National	1131198 Ba	Ito, Md.
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	T 1	41
Suc	Joseph Lings	styneral	170me Md 2121
	23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardial	or respiretory errest	Approximate
1	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial and the cause on each line.		Approximete Intervel Between Onset end Death
	Immediate Cause (Final		
r	disease or condition resulting In deeth) e. NENAI TAILUTE		
5	Due to (or as e consequence of):		
를	b. Hypertension		
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VMedicai	thet initieted events resulting in death) Lest Due to (or as e consequence of):		
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0	Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobecco	uee contribute to the cause of dec
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Completed		performed?	evelleble prior to completion of cause of deeth?
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ä	2 Accident investigation M 1 Yes 2 No		
Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end City or Town, Stete)	d Number or Rurel Route Number,
Ö	Salari (apasiny)	.,,,	
<u>a</u>	29a. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place	e, end due to the ceuse(s)	end menner es steted.
edicai	(Check only one) 2 Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, death occurrence on menner stated.	arred et the time, date end	place, end due to the cause(s)
×	29b. Signature end Title of certifier. 29c. License number	29d. Dat	e signed (Month, Day, Year)
		1 1	
	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Mital Dave, M.D., Go Maryland General		01/18
	30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)	/ // ,	
	Mitul Dave, M.D. To Maryland General	Hospital	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	7	
strar	JUL 3 0 1998 A Dia Navidan Boods 00		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death per Phy G762 8/3/98 EW 1. Decedant's Neme (First, Middle, Last) 2. Data of Deeth Month 26 Sharon 930 PM 27, 1998 414 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death 30 Ridgelawn Rd. Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. Months Davs Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthpleca (Stete or Foreign Country) Days 1 M 2 KF 212-70-4226 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 30 Ridgelawn Rd. 21136 U.S.A. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 1 Nevar Mertied 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: 1□ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantery/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumama) Virgil Herman Mary Kathryn Maconachy 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Streat end Number or Rurel Route Number, City or Town, Steta, Zip Code) James L. Layton Husband 30 Ridgelawn Rd., Reisterstown, Md. 21136 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 7/29/98 Baltimore, Md. 21 Signature of Funer 22. Neme end Address of Fecility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136 complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrast, only one cause on each line. Immediete Causa (Finel disaase or condition resulting in deeth) Breast Carcinoma Metastatic 18 months Due to (or as e consequenca of): Sequantially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or Injury that initietad avants resulting in deeth) Lest Due to (or as e consequence of): Due to (or es e consequence of) Part It. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of daeth? 24e. Wes en autopsy performed? 2 2 10 1 Yas 1 ☐ Yes 2 ☐ No 25. Wes casa raferred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 1 DNatural 28c. injury et Work? 28b. Time of 28d. Dascribe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at

'naturel', or items 23e or

marked other than

Department of Health and Mental I Important: If frem 27 Is marked of any Injury or other traumatic eve once.

Hyglene

Pages 1 and 2 should be filed within 72 hours efter

Baltimore, Maryland 21215-0020

Funeral Director

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Examine or Attending Physician: The law requires that the death certificate for use as certificate hes b lirector, page 2 s shis

Division of Vital Records, P.O. Box 687

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2. 16.

2 Accident

3 ☐ Suicide

4 Homicide

31. Dete filed (Month

Physician/Medical Certification:

death. s efter death.

I Director: A in by the for 24 hours within 24 hor To the Fune completely fi

Cartifying Physician: To the best of my knowladga, daath occurred at tha time, date end place, end due to tha ceuse(s) end mennar as statad.

2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at tha time, data end placa, end dua to the ceuse(s) end manner stated. 29b. Signature end title of cartifier tho completed cause of death (Item 23a) (Type, Print)

5 Pending invastigation

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

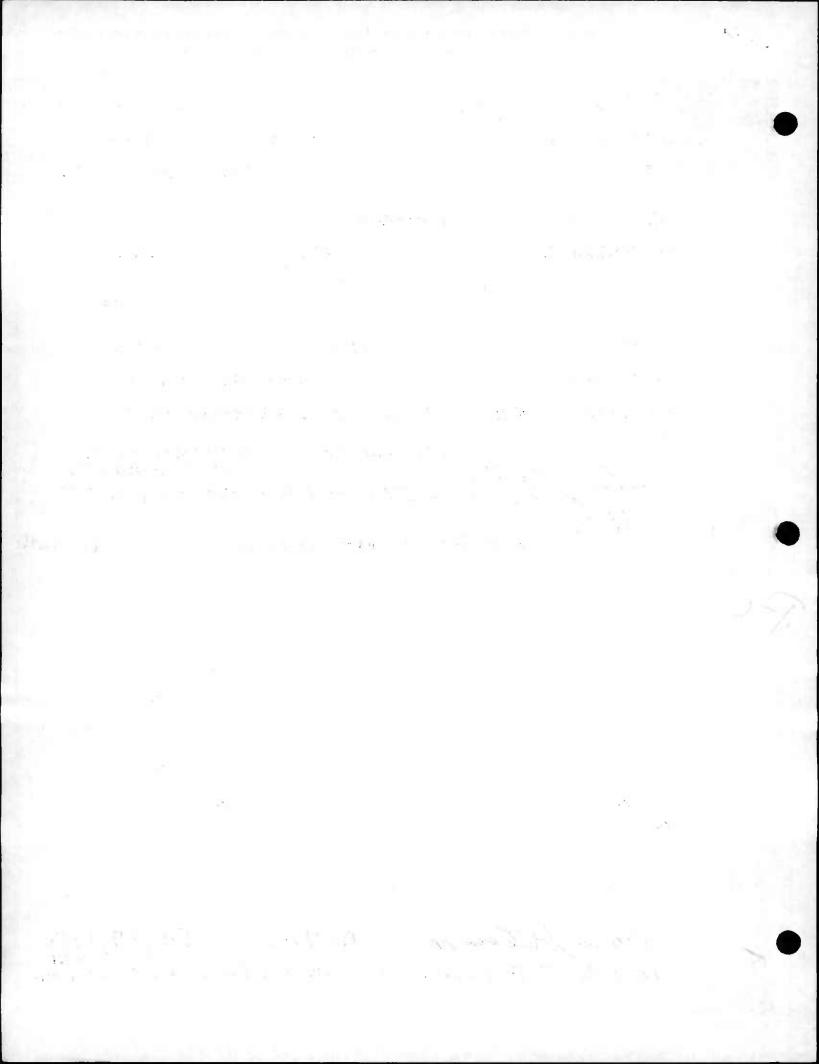
29d. Date signed (Month, Dey, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

St. Port Place Baltimore, mel. 301

State Registrar Feldman

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 21.50 **Physician** Month Le COMPTE LLOYD 0 7 1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Home For ALTIMORE eswick n curables N/A If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Months Days **Funeral** Birthplace (State or Foreign Country) Days 185 M 2□ F 548-09-7177 Director 90 Dec 11, 1907 Maryland Usual Residenca of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28a-f show any fujury or other traumatic event, the Med cal Examinet rount be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore County Director Towson 1 ☐ Yes 2 No 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 408 E. Joppa Road 21286 USA by Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Civil Engineer Steel Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Harry Lloyd LeCompte, Sr. 2 Bessie Meushaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Thomas P. LeCompte, Sr. (Son) 7103 Bristol Road, Baltimore, MD 21212

Ja. Method of Disposition

1 Burial 2 Nicremation 3 Benovel from State

20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7/27/98 Baltimore, Maryland 21. Signature of Funeral Service Nicessee

Martin D. Lawson 22. Name and Address of Fecility awson Mitchell-Wiedefeld Home THAT LIN D. LAWSON

6500 York Road Baltimore Maryland 21212

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate shock, or heer feilure. List only one cause on each line. Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting In deeth) /Medical ncer Examiner Lear Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Brid Due to (or as e consequenca of): Due to (or as e consequence of). P.O. Box To the Hospital or Attending Physician: The law requires that the death swithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendin compleiely filled in by the funeral director, page 2 should be detached for use. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à Completed 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicel exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No Certification: 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🕍 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signature and fittle of certif 29c. License number 29d. Date signed (Month, Dey, Yeer)

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1998

pleted cause of death (Item 23a) (Type, Print) 0

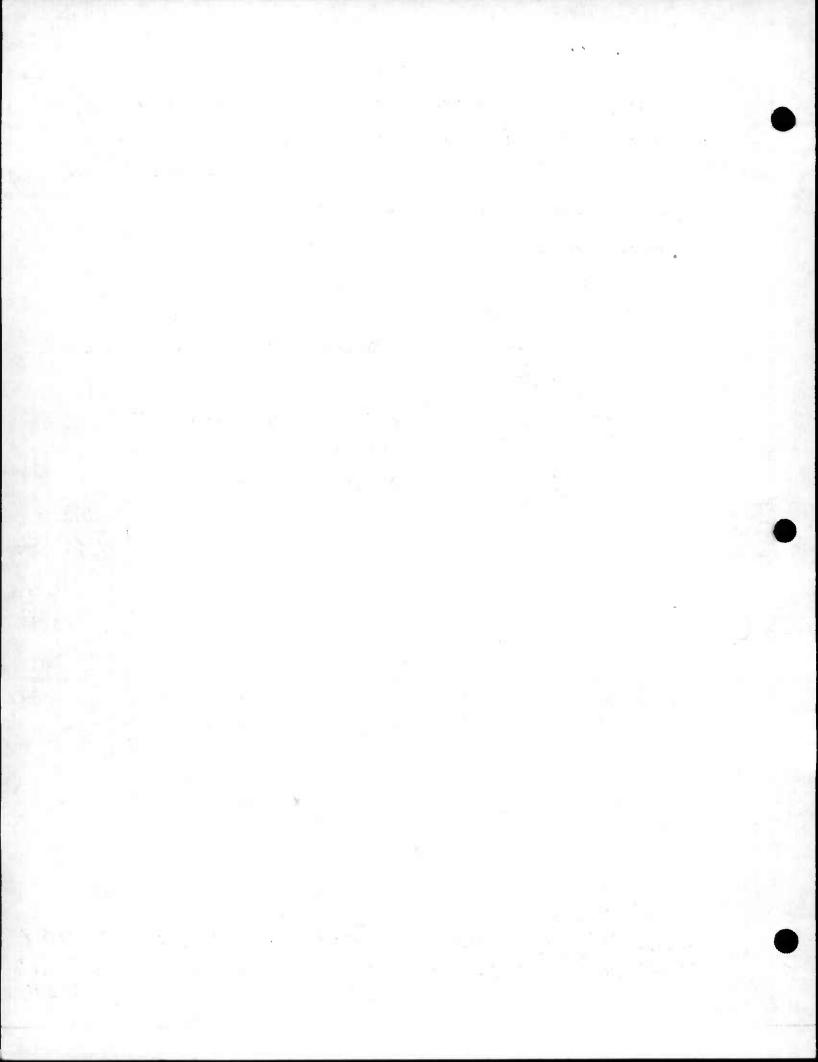
32. Registraris Signature

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State Registrar and add

DHMH 16 Rev 6/95

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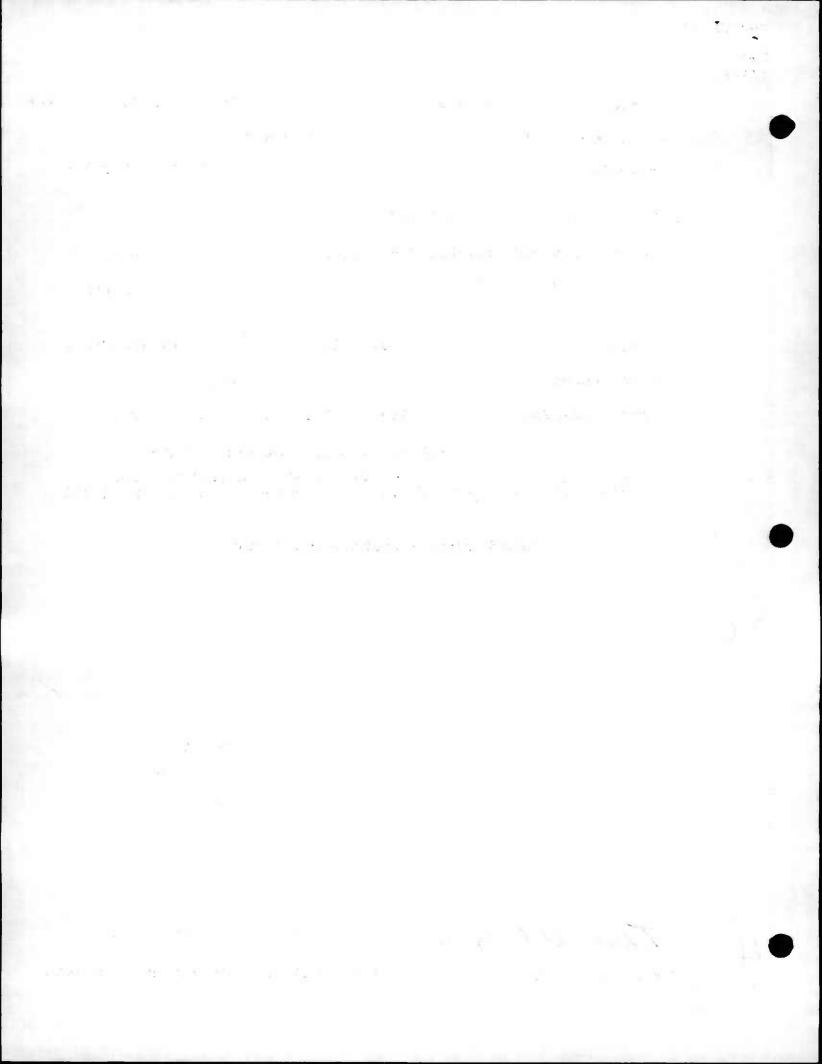
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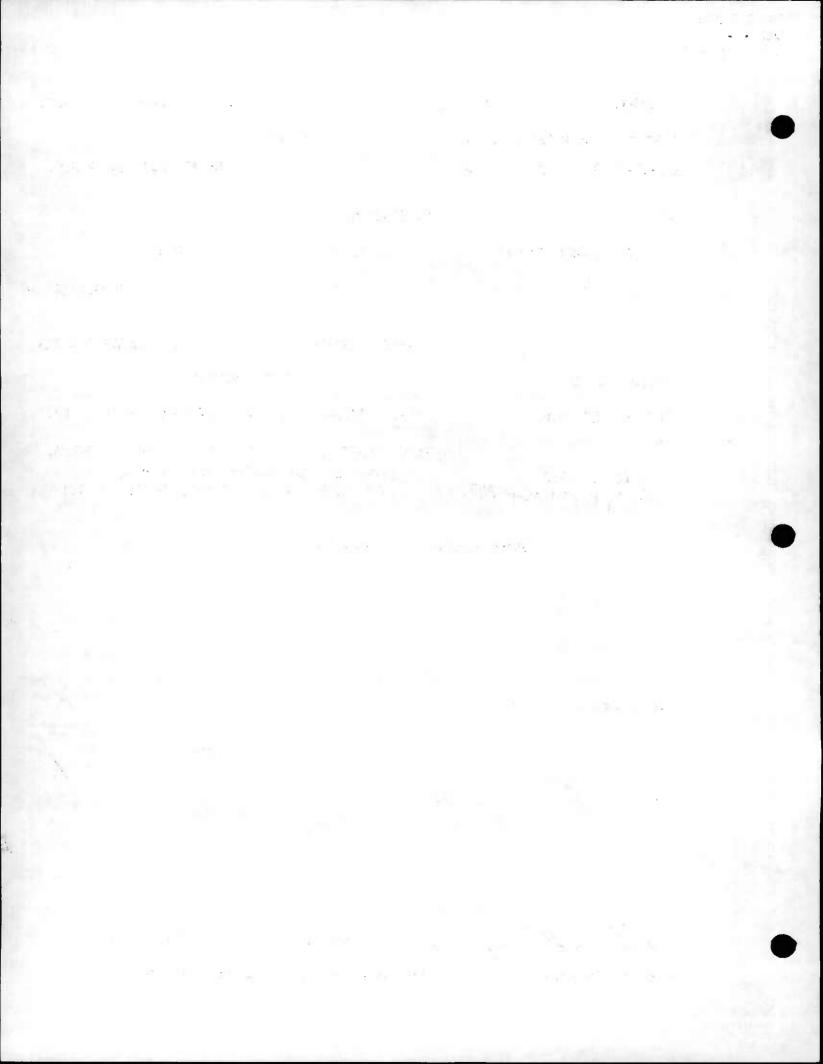
32. Registrer's Signature
Julia Navidon-Randalle



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State of Maryland / Department of Health and Mental Hygiene 98 22257

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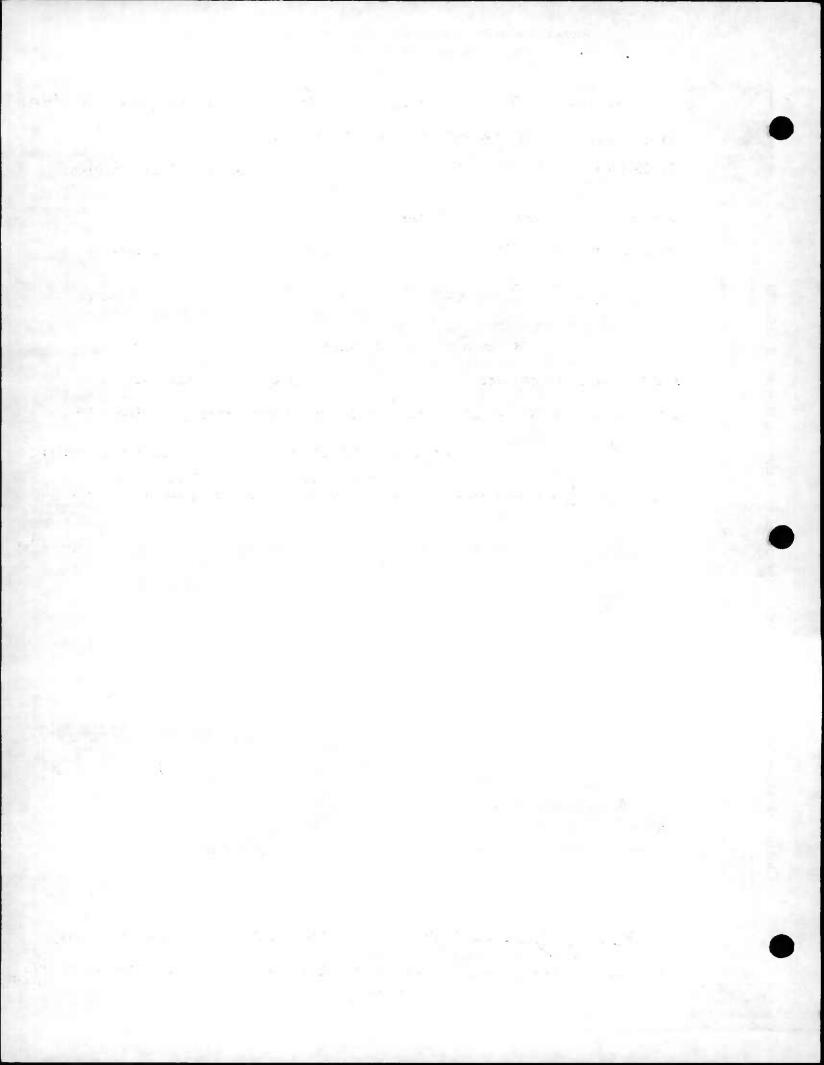


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State of Maryland / Department of Health and Mental Hygiene 98 23258

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19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Sireet and Numbar or Rural Route Numbar, City or Yown, Stea, Zip Code) 8324 Carrbridge Circle Towson, Maryland 21204 20b. Rates of Disposition (Print of Disposition (Print of Disposition) 21boration 3 (Print (Specify) 22c) Rates of Disposition (Print of Disposition (Print of Disposition) 22c) Rates of Disposition (Print of Disposition (Print of Disposition) 22c) Rates of Disposition (Print of Disposition (Print of Disposition) 22c) Rates of Disposition (Print of Disposition (Print of Disposition) 22c) Rates and Address of Facility Mitchell—Wildedfeld Home, Inc. 6500 York Road Baltimore, Maryland 21212 23c) Partic First (Print of Several or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory arrest. Immediate Cause (Final disease or condition) 10bus to (or as a consequence of): 10bus to (or as a consequence of): 11cus of Disposition (Print of Disposition) 12cus of Constitution (Print of Disposition) 12cus of Constitution (Print of Disposition) 22d. Was one or referred to medical to the cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print of Disposition) 22d. Was one or referred to medical to the Cause of Disposition (Print	To Be Comp	The second second second							17.11								
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	30. Name and address of person	on Milo	completed cause of de	eath (Item 23	a) (Type.	Print)										
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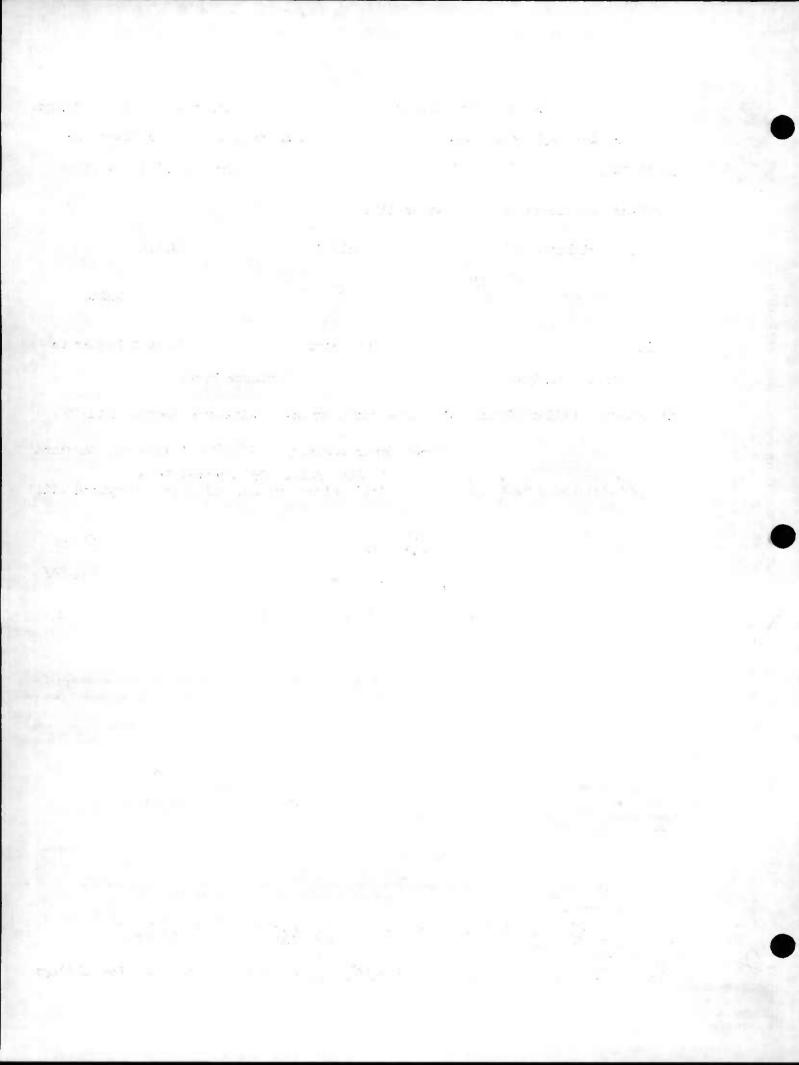
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dev Month Year **Physician** July 28, 1998 8:30pm Mary Louise Miller /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis-Brightwood Center Lutherville Baltimore Co. If Under 1 Year Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Days Months 1□ M 200 F 80 Yrs. Director May 11, 1918 Maryland 215-16-7018 Usual Residence of Decedent with the Marylend 10b. County 10c. City. Town or Location 10d. Inside City Limits Show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Medical Examiner must be nothined at Lutherville 1 XYes 2 No Baltimore Co. Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 515 Brightfield Road 21093 U.S.A r death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other than "natural", or item any Injury or other traumatic event 1 Never Married 2 Married altimore, Maryland 21215-0020 Specify: White 1 Yes 20XNo Specify: þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Black & Decker Co Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Frank Albright Marietta Harry 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Christopher Miller (Grandson) 1304 Burke Avenue, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/98 Baltimore, Maryland Green Mount Cemetery 22. Name and Address of Facility
A. Alan Seitz, Jr. Funeral Home 21. Signature of Funeral Service Licenses 3818 Roland Avenue, Baltimore, Maryland 21211 Approximate Intervet Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner equence of): Physician/Medical Examiner Neumo Ni Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Unspecified hutology) Division of Vital Records, P.O. Box 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was en autopsy performed? pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending efter deeth. 1 Yes 2 🗆 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 123 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) medical Attendisa 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) 4000 Old Court Rd # 203 Baltimore Schwartz ms 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State 30 his beinder-Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** /Medical 4b. City, Town, or Location of Death Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** N/A BALTIMORE 7. Age (In yrs Sociel Security Number If Under 1 6. Sex lest birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 12 M 2 F Months Days Hours PENNSYLVANÍA Director Usuel Residence of Deceder permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylan Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be inclified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE 1 Nes 2 No Director 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 3501 ST. PAUL STREET UNITED STATES 21218 Funeral 12. Was Decedent Ever in U,S. Armon Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: δ Specify: WKITE 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Eiamantary/Secondary (0-12), ARMED SERVICES UNITED STATES ARMY SECONDARY (12 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be KUSSELL LURK ETHELENE GREENWALT 2 19b. Mailing Addrass (Street end Numbar or Rurel Route Number, City or Town, Stete, Zip Coda) 19e. Informent's Name/Relationship (Type, Print) MILTON, PENNSYLVANIA 17847 BETTY FISHER SISTER RD#3 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Steta TWIN HILLS MEMORIAL PARK JUN31,1996 MUNCY, PENNSYLVANIA 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD K. Natson BALTIMORE MARYLAND 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or haart failure. List only one causa on aach line. Approximete Intervei Between Onset end Daath **Physician** /Medical Immediete Ceuse (Fine) disease or condition resulting in deeth) METASATIC CANCER Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if ony, leading to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68799 Due to (or es e consequence oi): The law requires that the deeth certificant ettending for use as signed by the el Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3∰Probably 4 Unknown 1 Yes 2 No HYPERTEMSION by Completed 24b. Were eutopsy findings eveileble prior to completion of ceuse of daeth? 24e. Wes an eutopsy performed? STRICTURE FSOPHAGUS After this certificate 1 ☐ Yes 25100 1 ☐ Yes 2 ☐ No al or Attending Physician: The setter death. Il Director: After this certificate of in by the funerel director, pa Be 25. Wes cese refarred to medical 26. Place of Deeth (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Deeth 28a. Deta of Injury (Month, Dey Yeer) Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ENaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At homa, farm, street, fectory, office building, etc. (Spacify) 4 Homicide To the Hospital within 24 hours e To the Funeral E completely filled pletely filled 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Cartifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D47945

State Registrar

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31. Deta filad (Month, Day, Year)

Marist

32. Registrer's Signature

Julia Davidon Pandolle

E. Mor

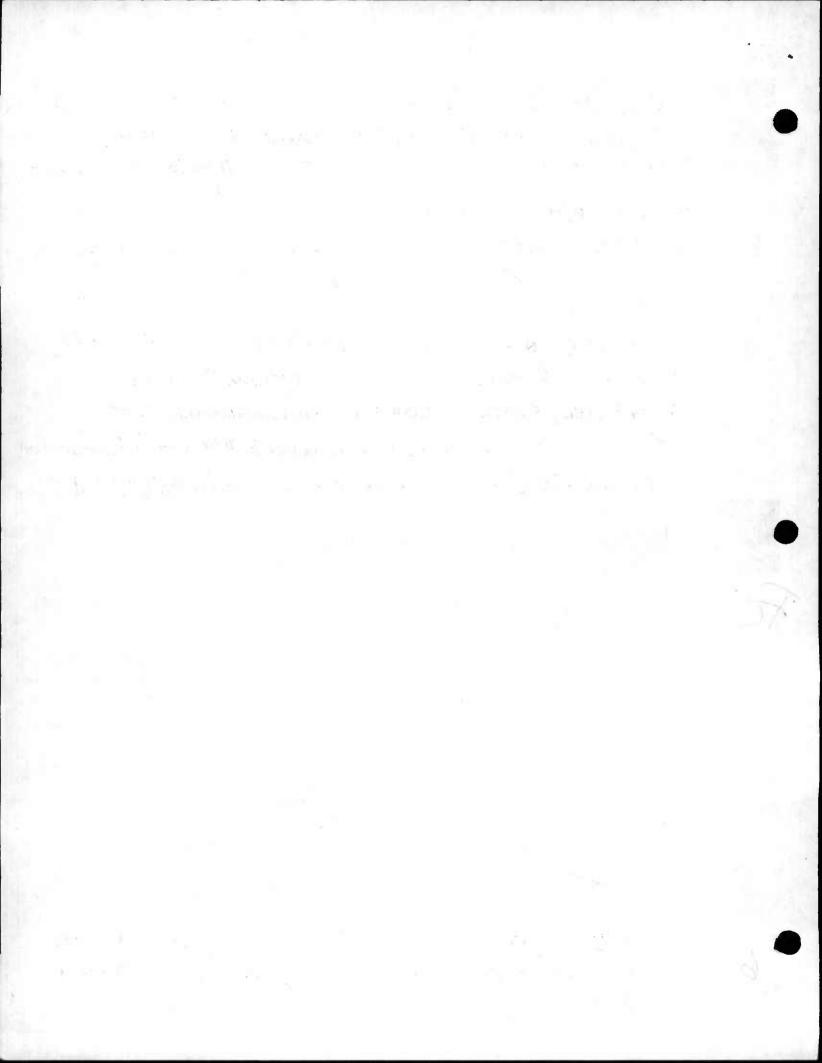
Partway Balhonne MV 21214

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

3007

Alrean

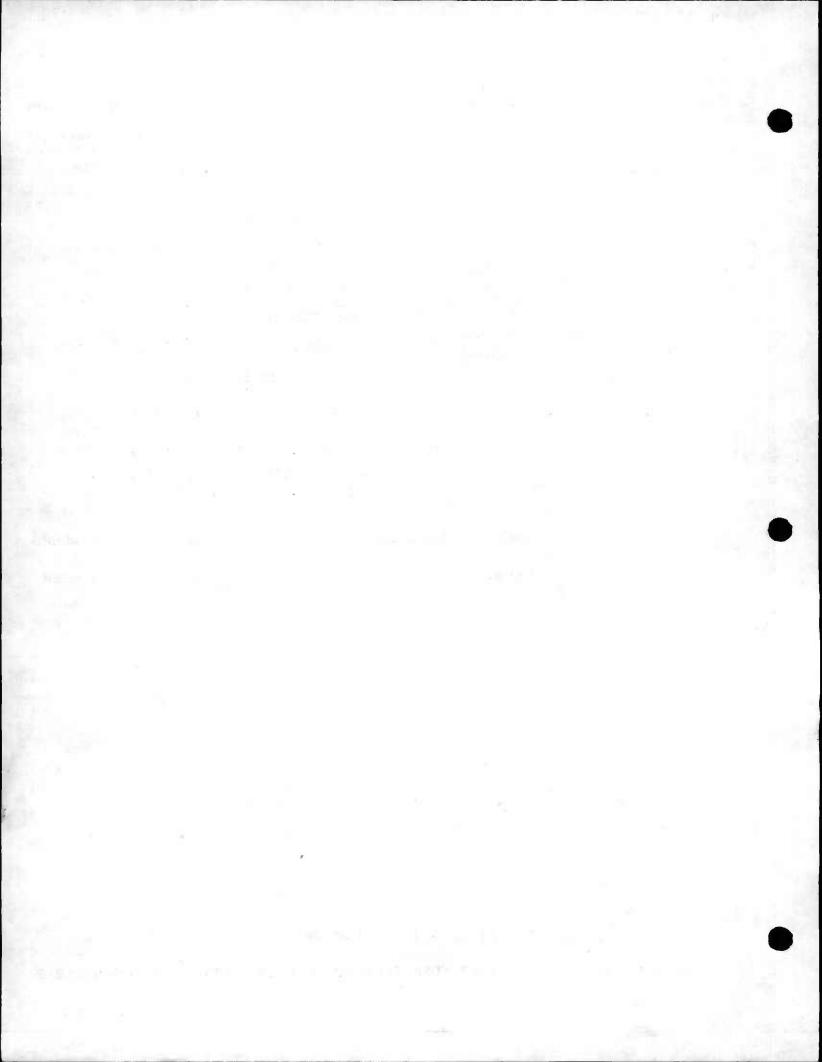
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 2326 |

			Ce	rtificate c	f Death		Re	g. No.			
Physician	Decedent's Name (First, Middle, La.	Donald Fr	anklin	Ruth			ate of Death Month	Dey	Year 998	3. Time of Death	
/Medical Examiner	4a Facility Name (If not institution, giv Saint Joseph		ter			wn, or Locatio		4c. County	of Death	more	
uneral irector	215-16-7511	ex 7. Age (In yrs. 7.4	. last birthday) Yrs.	Months De		Min. (Dete of Birth Wonth, Dey,			ace (Stete or Foraig try) yland	
f show	Usual Residence of Decedent 10a. Stata 10b. County		ity, Town or Lo	ocation		1 11	7.5	W	10	0d. Inside City Limits	
a or 28s-fe be notified Director		ltimore		10f. Zip Cod	8	ndalk	10	g. Citizen of V			
al', or fiama 23a or 28a-f show Examinar must be notified at by Funeral Director	1921 Walnut Aven 11. Marital Status 1 Never Merried 20 Merried 3 Widowed 4 Divorced	UE 12. Was Decedent Ever in U Armed Forces? 15. Yes 2 □ No If Yes, Give Year or Detes:		Was Decedent of the Yes, specify C	uban, Maxican	gin? (Specify	Yes or No- n, etc.)		e - America k, White, o	an Indian,	
"natural", adical Exe	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usuel Oc	cupation	of working	1	6b. Kind of Bu	usiness/Ind	lustry	
Completed	Elementary/Secondary (0-12) 9 Years	College (1-4or 5+)	lifa.	DO NOT use re	rired)	or worning		Law I	Enfor	cement	
arked otherstic event.	17. Father's Name (First, Middle, Last)					r's Nama <i>(Fir</i> therine		aiden Sumam Z	10)		
T le mar traumat	19a. Informant's Neme/Reletionship (Mrs. Virginia C.			ing Addrass (Str Walnut				-		Code) 1222	
reportants of themself and wasted other than importants if frem 27 is marked other than any injury or other traumatic event, that in once. To Be Compi	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐	20b.	cemetary, cre	osition (Name of metory or other Service	olece)			Oc. Location -			
Importa any inju pncs.	4 Donelion 5 Other (Specify) Hilltop Service Corp. 7/31/1998 Towson, 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland										
A fire buildings and a miner aminer aminer Examiner	Immediata Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SEPSIS Due to (COLITI for as a consector as a conse	quence of):					1	Onset and Deeth WEEKS WEEKS	
for use		d									
ed by the attendestached for u		ontributing to death but not re	sulting in tha u	tha underlying cause given in Pert I. 23b. Did tobecco use contribute 1 Yes 2 No 3 Pr						the cause of death pably 4 Unknow	
ate has been signe page 2 should be d Completed by			4				24a. Wes an perform		ava coi	are autopsy tindings ailable prior lo appletion of cause death?	
certificate has nector, page 2 Be Comp							1 ☐ Yes	s 2) No	10	Yes 2 No	
Sirector o Be	25. Was case referred to medical axaminer?	Hospital:			Other	of Death (Ch					
Aherthia funeral o	1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. I	ijury at Nork? □ Yas 2□	28d.	ma 5 ☐ Rasidence 6 ☐ Other (Specify) 28d. Describe how injury occurred			1)	
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28t. Location (Street and Numb. City or Town, Stata)									l Routa Number,	
Funer Funer stely fill dical	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my known of the basis of examination and manner stated.	owledge, daat ation and/or in	h occurred at the vastigation, in m	a tima, date en ny opinion, daa	d place, end of th occurred at	dua to tha car the tima, da	use(s) and ma ta and place,	annar as st and dua to	ated. the cause(s)	
To the comple	29b. Signature and vittle of certifier	1 ama	s M4	29c. Lic D38	950		29	d. Data signe	d (Month, i	Day, Year)	
0	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) MANUEL RAMOS, M. D., 6800 YORK ROAD, SUITE B, BALTIMORE, MARYLAND 21213										
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	eture					. 11111			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day 8, 1998 8:44P. M. **Physician** ROBINSON PRISCILLA /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Examiner Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 1 1923 5. Social Security Number Birthplece (State or Foreign Country)
 Maine 6. Sex **Funeral** 1□M 2□F 014-20-0522 75 Yrs. Director Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylal Department of Heelth and Mental Hyslene.
Important: If item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified anone. New York Accord Ulster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Airport Rd. 12404 Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Earl Raymond Steeves Elizabeth Vosmus 2 19e. Informent's Name/Reletionship (Type, Print) Mr. Peter Robinson/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 West King St. East Berlin, PA. 17316 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Hilltop Service Co. 7-30-98 4 ☐ Donetion 5 ☐ Other (Specify) Towson, MD. 22. Name and Address of Familionson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, MD. 21204 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onsat end Death **Physician** RESPIRATORY FAILURE DAYS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of):
RENAL FAILURE Physician/Medical Examiner DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): VALVULAR HEART DISEASE YEARS P.O. Box 6876 Due to (or es a consequence of): YEARS CORONARY ARTERY DISEASE signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? **SCLERODERMA** 1 Yes 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were eutopsy findings aveilable prior to completion of causa of death? Completed 24a. Was en eutopsy performed? certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ XNo 1 Yes 20 No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No edicai Certification: To Inpatient 2 ER/Outpatient 3 DOA this funeral 27 Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? After Division or Attanding 5 Pending investigation Netural 2 Accident s after dea. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 ☐ Homicide 1 **Exertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.
2 **Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steled. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number W D31826 .I wit 7-29-98 11 CUL

State Registrar 31. Dete filed (Month, Day, Year) 30 1998



30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)
RICHARD L. LINTHICUM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3263 Certificate of Death Item#8 per FH G761 7/31/98 EW Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 27, 1998 MARY Adelaide K. JULY 4:05p.m. SCHRECK /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Towson Baltimore if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Dey, Yeer) **Funeral** Days Months Hours Min. 1□M 2♥F 223 12 0593 Director Jan NOV 1 . 1917 West Virginia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show Maryland 1 ☐ Yes 2 ☑ No Baltimore Directo Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Houlth and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or items 23a or say injury or other traumatic event, the Modical Expression and be note. 818 Martin Rd. 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LPN Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Lee Hughes Kraft Irma Ansell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Adelaide M. Watson (Daughter) 1918 Poplar Rd. Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gardens 7/30/1998 Bel Air, Md. 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final aEND STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examir deeth certificate be axecuted attending physicien end for use as the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68780 Physician/Medical Due to (or as a consequence of): ed by the detached Part II. Other algnificant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? The law requires that the 3 Probably Unknown 1 Yas 2 No signed to þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Aftar this certificata has funeral director, page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 $\c M$ Other (Specify) $\c HOSPICE$ 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending investigation 1X Natural death. М 1 ☐ Yes 2 ☐ No ector: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours aftar of To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cal 29a. Certifier (Check only one) 29c. Licenee number / 1/5504 29b. Signature and till 29d. Date signed (Month, Day, Year) dehods 7.28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093 33 Registrar's Signature 31. Date filed (Month, Day, Year) State 3 0 1999

DHMH 16 Rev 6/95

Registrar

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Large E C Co. La Section 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23264 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 1998 15Am Harrie nearn /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner lenBurnie Ann Arundel lariner 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 219–26–3649 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 □ M 2√2√F 88 Yrs. Director Feb. 1, 1910 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f shov to Medical Examiner must be notified at Md. Anne Arundel Glen Burnie Director 1 ☐ Yes XXNo 10e. Street and Number Mariner Health Nursing Home 10f. Zip Code 10g. Citizen of Whet Country? 7355 Furnace Branch Road East death v IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. e filed within 72 hours efter if Hygiene. other than "natural", or Ita 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes No Specify: Specify:Black ₩idowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8th Grade Housekeeper/Supervisor Provident Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic evant sones. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Grooms Eliza Dorsey 19a. Informent's Name/Relationship (Type, Print) (rint)
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Granddaughter 6210 Cheverly Park Dr. Denise Lyles 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremetion 3 ☐ Removal from State Bushy Park Aug. 1 Howard County, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical ACUTE ISCHEMIC EVENT. Immediate Ceuse (Finel 1 HOUR diseese or condition resulting in deeth) **Examiner** METASTATIC BREAST CANCER Examiner 1 YEAR Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Lest Due to (or es e consequence of) Physician/Medical Box 6876 Due to (or es e consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ARTERIOSCICAC CANDIDVASCULAR DISCASE Records. by il or Attanding Physician: The law requires t efter death. I Director: After this certificate has been signi 24b. Were eutopsy findings avallable prior to completion of ceuse of deeth? Completed OLD CENERIO VASCULM ACCIDENT 24e. Wes en eutopsy 1□ Yes 2⊠No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 454 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funeral D 15 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated. Medicai completely (Check only

29c. License number

D-22609

7445 FURNACE BRANCH. Rd Gleu BURNIE Md 21060

29d. Dete signed (Month, Day, Yeer) JULY-27-1998

State Registrar 29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)

RUBEN

3 0 1998

4.9.

M.D 32 Registrer's Signature

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

REIDER

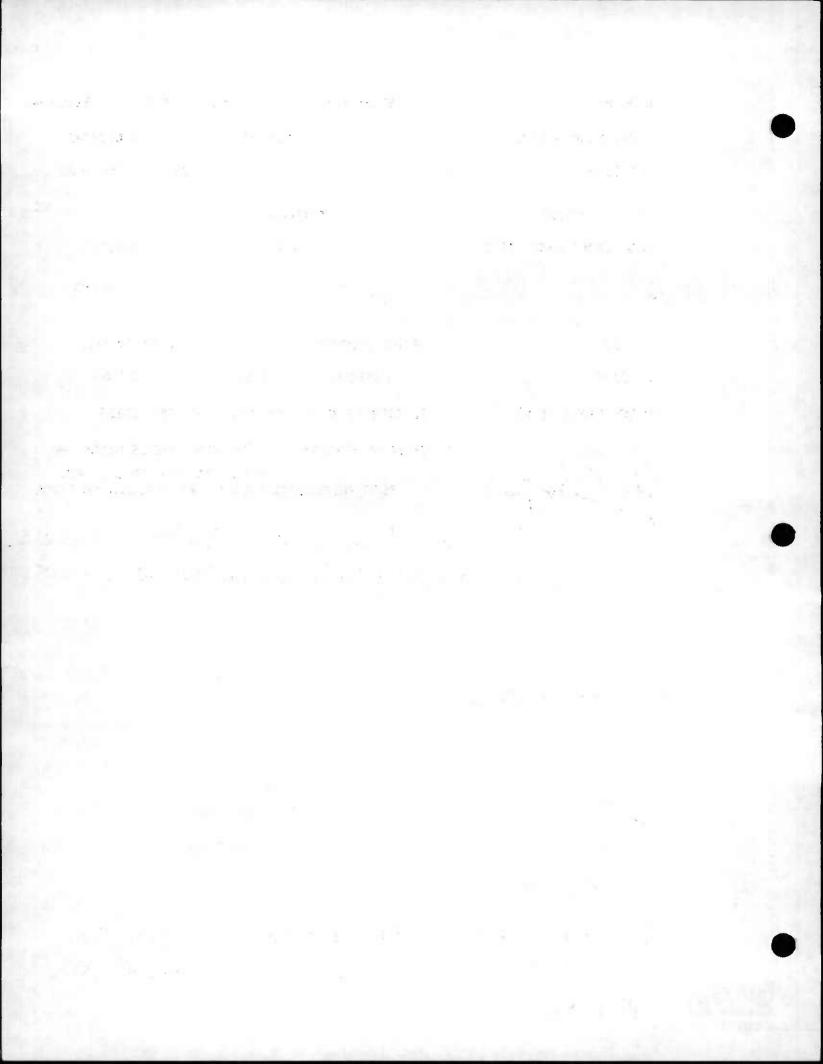
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			State of W	aryland /	Certificate of			g. No.	23265		
Dho	-1-1	1. Decedent's Name (First, Middle, L	ast)		2. Dete of Death Month	Dey Yeer	3. Tima of Death				
	sician edical	DOROTHY			SCHREIBER		JULY 26	1998	11:00 AM		
	miner	4a Fecility Neme (If not institution, g	ive street end number)	4b. City, Town, or Le	ocation of Deeth	4c. County of Dee	th				
		PIKESVILLE N				BALTIMO					
Fune	_		Sex 7. Ag 1 ☐ M 2 🂢 F	ge (In yrs. lest b	irthday) If Under 1 Year Months Days		8. Dete of Birth (Month, Dey,)				
Direc	tor	085-03-7704 Usuel Residenca of Decedent		85			FEB.24,1913 NEW YORK				
yland		10a. State 10b. County		10c. City, Tov	vn or Location		10d. Insida City Limits				
h the Marylan r 28a-f show	to.	MD HOWAI	RD		C	OLUMBIA	1 ☐ Yes XXNo				
th th	Director	10e. Street end Number			10f. Zip Code		10	g. Citizan of What C	ountry?		
23a	a la	6336 CEDAR LA	ANE #247			21044		U.S.	.A.		
-0020 2 hours after death with the Maryland stural, or Herns 23a or 28a-f show	by Funeral	11. Meritel Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ It Yes, Give Yeer or Detes:	•	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2XXVo		ecify Yes or No- Rican, etc.)	Bleck, Whi	ite, etc.		
21215-0020 d within 72 hours af giene. or than "natural; or		15. Decadant's I (Specify only highest g Elementary/Secondary (0-12)		5+)	Decedant's Usuel Occu (Giva kind of work dona lifa. DO NOT use ratire	during most of work ed)	king	6b. Kind of Businass			
		12 17. Fether's Neme (First, Middle, Las		O	FFICE MANAGE			BEAUTY PAR	TIMORE Introduce (State or Foreign Journal) EW YORK 10d. Insida City Limits 1 Yes XXNo Country? A. Increase Indien, lite, etc. WHITE Is/Industry RLOR NER Izip Code) 33 or Town, State ILLS, MD ILLS, MD Approximate Intervel Between Onset and Death Onset and Death Country?		
Maryland d 2 should be file th end Mentel Hy T Is merked othe	To Be	WILLIAM	.,		GOLDBERG	100000000000000000000000000000000000000	ame (First, Middle, Meiden Surneme) COSE WERNER				
lar s me		19a. Intormant's Name/Raletionship	(Type, Print)	19	b. Malling Addrass (Stree	t end Number or Rui	rel Route Number,	Cify or Town, State,	Zip Code)		
E = 6/1 /		KEN SCHREIBER	(SON)		OJIBWAY RO	AD RAND	NDALLSTOWN, MD 21133 Data 20c. Location - City or Town, State				
Tages 1	5	20e. Mathod of Disposition 1 XBurial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec		ocation - City or Town, State							
Baltimore,	SCS SCS	21. Signature of Funeral Service Co		110 41	22. Name end Addr	ess of Fecility	7/28/98 L LEVINSO	ON & BROS.			
m KQE	8 8	Jan (Nou	Lews		8900 REIS	TERSTOWN					
Physici /Medic Examin	cal	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions,	_	ebro	1	ian Pac	cide	t			
the death certified be seen by the attending physician and	Clan/Medical Ex	Sequentially list conditions, if ery, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c	Due to (or es e	consequenca of):						
P.O.	Physician	Pert II. Other significant conditions Mild dam	contributing to deeth b	out not resulting	in the underlying cause g	iven in Pert I.			e to the cause of death? Probably 4 Unknown		
Records, P.O. Both In the learn he law requires that the death enables signed by the attended to the control of	Completed by						24e. Wes en perform		Wara autopsy tindings eveileble prior to completion of cause of daath?		
	E O						1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No		
ital	BeC	25. Was case rafarred to medical				26. Place of Deal	th (Check only ona				
- 5 00	ToE	axaminar?	Hospitel:	ent 2 ER/C	tutpetient 3 DOA	ther: 4 Dursing Ho	ome 5 Residen	ice 6 Other (Spi	ecify)		
VISION OF Attending Physical Attentions of A	0 00	27. Manner of Death 1 Naturel 5 Panding 2 Accident Investigati	28e. Dete of Inju (Month, Da	iry 28b.		ury et ork? ☐ Yas 2 ☐ No	28d. Describe hov	v Injury occurred			
5 p# 9 5	Certification:	3 Suicide 6 Could not determine	d 286. Pieca of in	jury - At home, t c. (Specify)	erm, street, fectory, office		28f. Location (Stre City or Town,		end Number or Rurel Route Number, ste)		
To the Hospital within 24 hours of To the Funeral Completely filled	edical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysicien: To the best iminer: On the bests o end menner st	t exemination e	a, daeth occurred et the t nd/or Investigation, In my	ime, dete end plece, oplnion, deeth occur	end due to the cer red at tha time, da	use(s) end menner a te and placa, and du	is steted. ia to tha ceuse(s)		
To th Within	W	29b. Signeture end title of cartifiar 29c. License number 29d. Date, signed (Month, Day,									
	9	30. Name end eddress of person who	completed cause of a	deeth (Item 23a)	(Type, Print) oad, S	ite 3	1,9,0c	Esull	bH,		
	State	31. Dete tiled (Month, Dey, Year)	32. Registr	rar's Signetura					1		

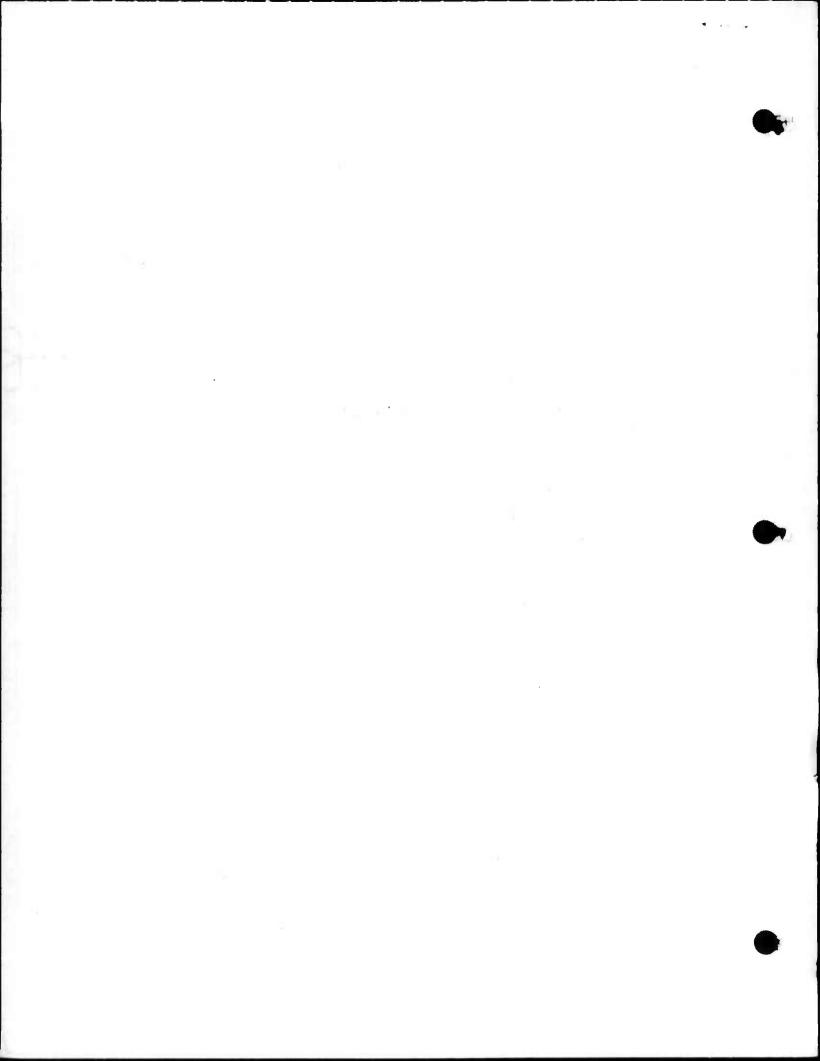
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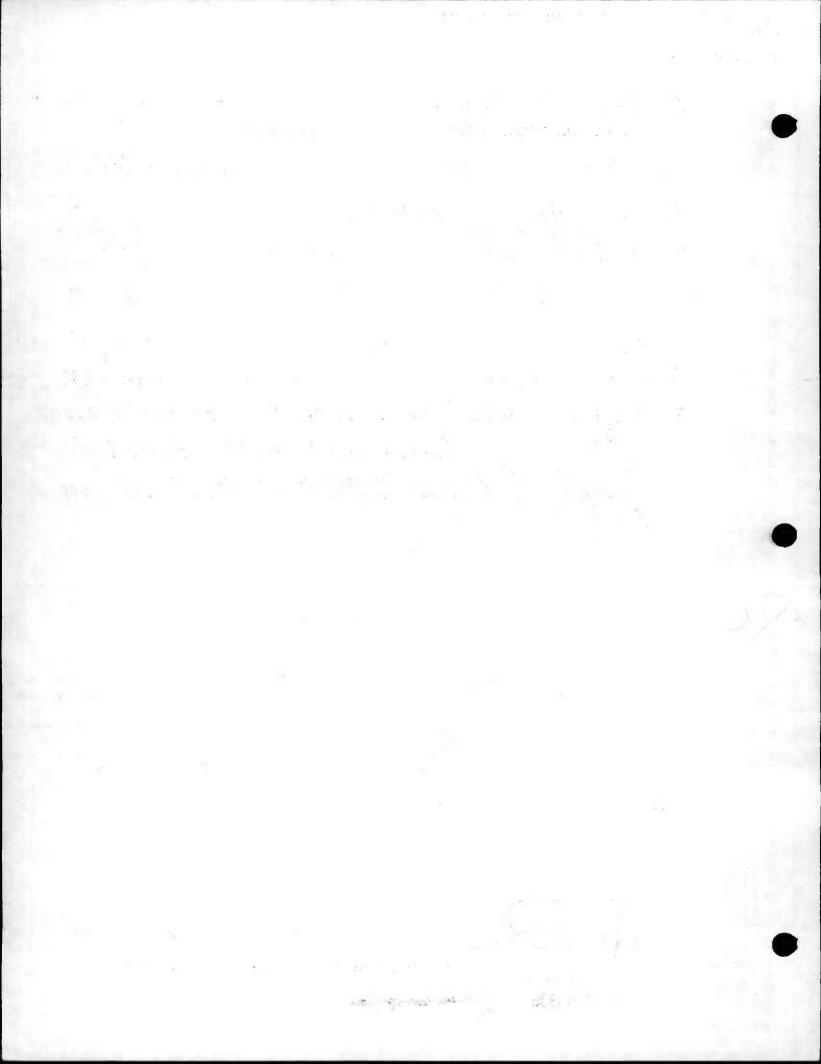


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	1 - STATE REGISTRAR	STATE OF I			ICATE OF		D ME	NTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)		24				2.	DATE OF DEATH	ıv.	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	HM 4+					\perp	7 28	10	798	124 fmim
	216-48-2415	5. SEX	8. AGE (In yrs. It	est birthday) YAS.	MONTHS DAYS	HOURS MIN		DATE OF BIRTH (Month, Day, Year)	4004	Countr	
Ì	9a. FACILITY NAME (If not institution, give st		96		9b. CITY, TOWN	OR LOCATION OF				Balt	imore, Md.
E E	Genesis Perring					rkville			100	Balti	
ן בַּ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			I 100 CI	Y, TOWN OR LOCA						
DIRECTOR	Md.	N/A		100.01		Baltimo	re C	itv			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	10e. STREET AND NUMBER					. ZIP CODE		203	10g. CIT	IZEN OF V	WHAT COUNTRY?
BY FUNERAL		lenmore					212			nited	States
5	11. MARITAL STATUS 1 Never Married 2 Married		YES 2 X		If yes, sp	ecify Cuban, Ma	xicen, Pi	ORIOIN? (Specify Yes uarlo Rican, atc.)	or No	14. RACE Black	— American Indian, c, White, atc.
	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE Y	WAR OR DATES		1 TYES	2 ∑ NO Sp	ecify:			Speci	White
	15. DECEDENT'S EDUC (Specify only highest grade			Give kind of	USUAL OCCUPATION	ON ost of working		16b. KIND OF BUS	BINESS/IN	DUSTRY	
1	Elementary/Secondary (0-12)	College (1-4 or 5	+)	b. Do NOT u	emaker				Own Ho	200	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			HOIR	elliakei	18. MOTHER'S	NAME (First, Middle, Maiden		Jille	
TO BE COM	Rosc	oe Shipl	.ey					garet K		copf	
10	194. INFORMANT'S NAME (Type/Print)	. (0.)						Number, City or Town			
	Edward R. Schmuff	(Son)					Bal.	timore, N		_	21206
	1 Donation 6 Other (Specify)	oval from Stata	cemetery, cr	e AND DATE	of disposition (Na other place) Te Cemete		7/3	1/98 Bal		City or To	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Milton			22. NAME AI	ND ADDRESS OF	FACILIT	Leonard			
	> milton .	Knin	ATT		5305	Harfor	d Ro	oad Balt		,	
	23. PART I. Enter the diseases, of c	omplications the	t causad/the d	aath. Do							Approximata
	ahock, or heart failure. I IMMEDIATE CAUSE (Final	List only ons car	ise on aach lin	a.	1	4	11	2			Interval Batween Onast and Death
	disease or condition resulting in death)	400	2 herr	7			K	- sen	0		Hers
		DUE TO	(OR AS A CONSE	EOUENCE O	P):						0
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	EQUENCE O	F):						
2	CAUSE (Disease or Injury										
Ė	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	F):						
S	OART II OR I III III										
S S	PART II. Other algorificant conditions	contributing to	death but not	resulting	In the underlying	g cause given	in Pari	1 1. 24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	10:00	la-	1, 1	211	ies	1	707	1 - YES 2	t no-	7	OF DEATH?
	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DE	ATH Y	S NO E	UNCERT	AIN [- I			1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check only one)						
YSI	1 TYES 2 THO	1 Inpatient 2		_	OTHER:	e 5 🗆 Residen	ce 6 🗆	Other (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF (Month, D		26b. TIM	JURY WO	URY AT PRK? YES 2 NO	280	J. DESCRIBE HOW I	NJURY OC	CURED	
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	25a. PLACE O	F INJURY — At h	ome, farm,	streat, fectory, offic		251	LOCATION (Street a	nd Number	or Rural R	oute Number
TED	4 Homicide detarmined	building,	etc. (Specify)					City or Town, State)			
PLE	29a. CERTIFIER (Check only	IAN: To the best of	my knowledge, d	eath occurr	ed at the time, data	and place, and	due to th	ne cause(s) and man	ner sa sta	ted.	
COMPLET											and menner as stated.
BE	296. SIGNATURE AND TITLE OF GERTIFIER	KUD				DOS	3	O	29d. DAT	E SIONED	(Month, Day, War)
2	30. WAME AND ADDRESS OF PERSON WHO	PAT	SE OF DEATH (ITE	EM 27) (Type	Peu	12	Pa	rfus	, /	e,	How
	31. OATE FILED Month 2 0 1998	32 HERISTHA	A'S SIGNATURE	indelle	,						, , , , ,
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98-4258-510 B.K.S	Amend: #10e Per FH Fi	m G761 7-30-98RC Type or Print in I	Black Indelib	le ink. Assure /	All Copies Are	Legible.
KIMBERLY TH	IOMAS PART I, II, 27,28A-F PE	•		nt of Health and te of Death	Mental Hygiene Reg. No	20 201
Physician /Medical		D TI.	ias		2. Dete of Deeth Month De JULY 26,	Yeer 3. Time of Deeth 4:30 AM
Examiner	An Parille Mama //f and innehiting of			4b. City, Town, or BALTIMO		: County of Dough
Funeral Director	5. Social Security Number 6. S 215-94-4151 Usual Residence of Decedent	Tex	lest birthday) If Und Month	er 1 Year If Under 24 Hrs s Deys Hours Min		9. Birthplece (State or Foreign fountry)
the Maryland 28a-f show notified at	10a. Stete 10b. County	A 10c. Cit	y, Town or Location Baltima	re		10d. inside City Limits 1 Ø¥Yes 2 □ No
ier death with the Maryle flore 23s or 28s-1 sho for mart be notified at	10e. Street end Number 510 E	NORTH AVENUE		21202	10g. Cit	tizen of Whet Country?
020 urs after death with the Ma ai', or items 23s or 28-1 s Examine, must be notified by Funeral Director	3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		edent of HispenIc Origin? (secify Cuban, Mexican, Puer 254 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
d 21215-0020 filed with the Maryland Higher with the Maryland Hygiene. ther than "natural", or items 23s or 28s-1 show out, the Medical Examiner must be notified at a Completed by Funeral Director	15. Decedent's E (Specify only highest gr.	ducetion ade completed) College (1-4or 5+)	1/	suel Occupation work done during most of wo use retired)	orking 16b. K	find of Business/Industry ursing Home
Maryland 212: d2 should be filed within the and Mental Hygiena. 7 is merked other than traumatic event, the M	David C	Thomas		Step	me (First, Middle, Malder Nan I E	Hancock
ore, Maryland 212. es 1 and 2 should be filed within of Health and Mental hygiene. I flem 27 is merked other than r other traumetic event, the M	19a, Informent's Name/Beletionship (Mrs. Stephanie) 20a. Method of Disposition	Thomas	19b. Malling Address 510 E. Place of Disposition (Accemetery, crematory of	ss (Street and Number of F North Avi Jame of r other place)	2. Balt	or Town, Stete, Zip Code) To, Md, ZIZOZ ocation - City or Town, Stete
Peg Peg Peg ury o	1 Buriel 2 ACremation 3 4 Donetion 5 Other (Special Service Life)	y) Grand From State Grand From State	reenmo	unt Crematory	8/1/98 Ba	ilto. Md.
Palt Balt Balt Balt Balt Balt Balt Balt B	Immediate Ceuse (Final	plications that caused the deel one cause on each line.		oh L. RUSS W. North ode of dying, such es cerdie	Funeral Ave, Balta correspiretory errest.	Md. 212/6 Approximate Interval Between Onset and Death
Examiner	disease or condition resulting in deeth)	θ	INTOXICATION or es e consequence o	f):		
Minsit	if any leading to immediate	b Due to (c	or es e consequence o	n):		
riffication or an arrange or arrange or an arrange or arrange or an arrange or an arrange or arra	ceuse. Enter Underlying	cDue to (c	or es e consequence o	():	- 177	
P.O. Box (hat the death certify but the death certify but by the attending deteched for use at Physician/Me	Pert II. Other significant conditions of	d.	ulting in the underlying	r cauco abron in Part I	23h Did tohacco	o use contribute to the cause of death?
b, P.O. that the do ned by the a detached	ASTHMA	onthoding to death out not les	unting in the underlying	Cause given in r att i.	1 Yes 2	
Division of Vital Records, P.O. Box 6878 or attending Physician: The law requires that the death certificate the effer cleath. Director: After this certificate has been signed by the attending present in by the funeral director, page 2 should be detached for use as in burnerfill cation: To Be Completed by Physician/Medical					24e. Wes en euto performed?	24b. Were eutopsy findings avellable prior to completion of cause of deeth?
f Vital Regenter The le sentificata ha director, page:	25. Was cese referred to medical		SE.	Of Plans of D	•	2 □ No 1 No
Si direction		Hospitel: 1 ☐ Inpatient	ER/Outpetlent 3	Other:	eeth (Check only one) Home 5 Residence	6 □Other (Specify)
ion o nding Ph ath. r: After th he funeral	27. Manner of Death 1 Neturel 5 Pending 2 Accident Investigetio	28e. Dete of Injury (Month, Dev Year) FOUND 7-26-98	28b. Time of Injury A	28c. Injury et Work? 1 ☐ Yes 2 🏋 No	28d. Describe how Inju	ry occurred
Division o To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification: 7	3 Suicide 6 M Could not be determined	building, etc. (Special FOUND: HOTE	L ROOM		BALTIMORE CI	
• Hosp 1 24 ho • Fune sletaly f	29a. Certifier (Check only Medical Example)	ysician: To the best of my kno niner: On the basis of examine menner steted.	wiedge, deeth occurre ation end/or investigetion	ed at the time, date and place on, in my opinion, death occ	e, end due to the ceuse(s urred et the time, date en	s) end menner es steted. nd place, end due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	Z.	2	9c. License number O.C.M.E		ate signed <i>(Month, Dey, Year)</i> JLY 26, 1998
2	(dont)	completed cause of deeth (iter		eet, Baltimo	re, Maryland	1 21201
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Signa	ature			



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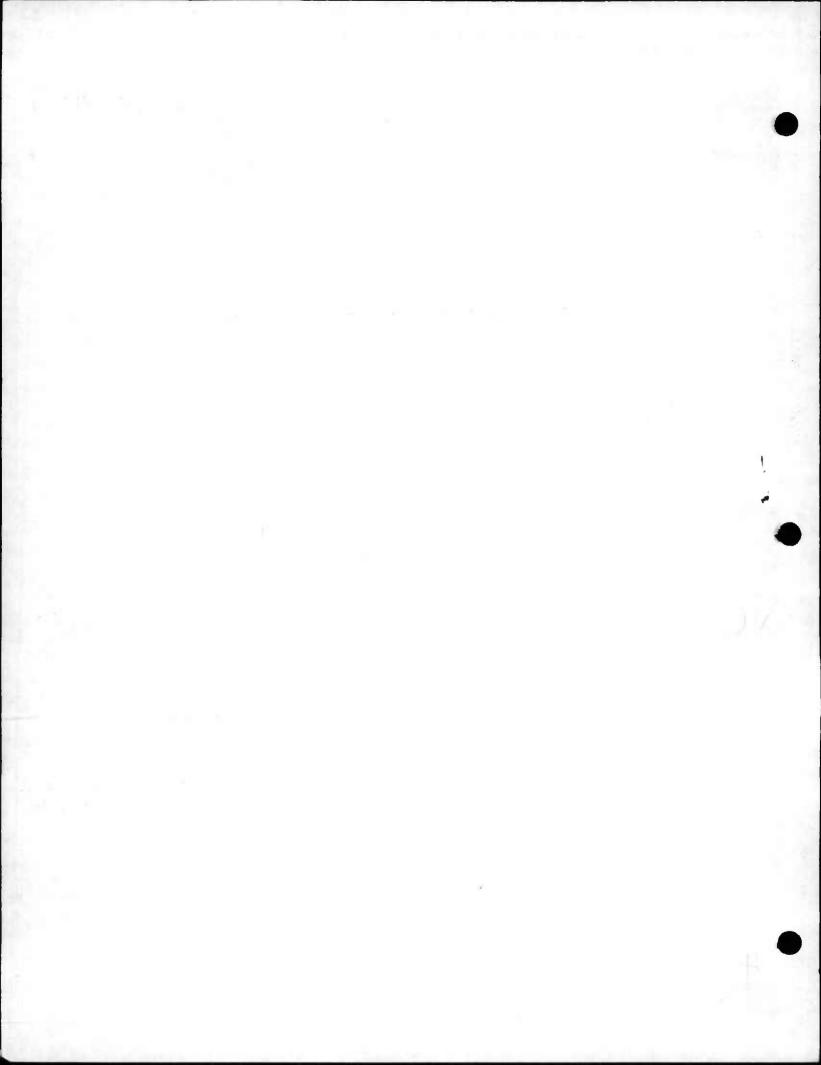
State of Maryland / Department of Health and Mental Hygiene

23268 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Williams 26 9:10 am /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore ella Mercy NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) //- 2 2 -/9 Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days 217-16-6358 Director Usuel Residence of Decaden TPeges 1 end 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23s or 28s-f show 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene.
Important: If New 72 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exprision means to notified at Baltimore 1 Yes 2 No by Funeral Director Ma NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? pnia Avenue 21206 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S.F. +6 10th grade Dervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kobert Moore 10 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt B Williams Balto, rul Husband Baltimore, 20a. Method of Disposition 20b. Placa of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Kidge 21. Signature of Funeral Service Licenses 4300 Warre Chabash Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical BRAIN TUMOR UNANOUN Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequenca of): ate has been signed by the attending pripage 2 should be dateched for use as it The law requires that the death certific Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? certificate has 1 ☐ Yes 23 € No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) STELLA MARIS AT MERCY Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1405 Pice Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1. Matural 5 Pending investigation death. 1 Yes 2 No 2 Accident efter deat 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide in by t 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C Medical (1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Tono 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) selai- Red 7672 32170 21236 31. Date filed (Mopth Day Yea 32. Registraric Signature Fundale State Registrar

MARIE

WILLIAMS,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1: Decedent's Name (First, Middle, Last) Day Month Year **Physician** Andrew Wingate July 3:00 PM 25 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Hospital Bultimore Sinai | H Under 1 Year | If Under 24 Hrs. | S. Date of Birth (Month, Dey, Year) | O7-13-14 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Vre 250-18-6583 84 Director SC Usuat Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limifs 10a. State 10b. County d other than "natural", or items 23s or 28s-f show event, the Med call Examiner must be notified at XXYes 2 No Md NA Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4117 Rolandview Avenue 21215 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours efter 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Various trades 6th Grade NA Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 end 2 should be Department of Health and Mental Important: If Item 27 is marked of eny Injury or other treumatic eve page. John Wingate Millie Bradley 2 19e. fnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1615 N. Milton Avenue Baltimore, Md. Miriam Brown 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - Cify or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Nat'l Mem. PK. Cem 07-31-98 4 ☐ Donetion 5 ☐ Other (Specify) MD. Laurel, MD 22. Name and Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses WM.C.March FH 1101 E. North Avenue 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final 7 Days Bleed Gastrointestinal diseese or condition resulting in death) **Examiner** Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Vital Records, P.O. 8 signed by t 1 Yes 2 No 3 Probably 4 Miknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' page 100 1 Yes 2 No 1 Yes 2 No certificate Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 SInpatient 2 □ ER/Outpatient 3 □ DOA to Se in 28c. fnjury at Work? 28e. Date of fnjury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Atta Attending 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 | Homicide To the Hospital
within 24 hours a
To the Funeral D
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature end title of cartifier 29d. Date signed (Month. Dav. Year) 29c. License number Gremone Do AS-2402321-JR9494 July 25, 1998

Justin farth

Baltimore Maryland

Rosemore

alais

State Registrar 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

West

2401

31. Date filed (Month, Day, Year)

Belvedere Avenue

32. Registrar's Signature ... Randase.

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TOPE OF THE PERSONAL INTERPRETATION

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1 Decedent's Nama (First Middle Last) Month JULY 27, 1998 **Physician** 11:30 A.M GEORGE WASHINGTON /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1916 W. FRANKLIN STREET. (HOME) BALTIMORE 8. Data of Birth (Month, Day, Year) SEPT 8,1925 9. Birthplaca (Stata of Foreign Country) If Undar 1 Year If Under 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1√ M 2□ F Days Months Hours CHARLOTTESVILLE Director Usual Rasidance of Dacedant the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10b. County show r than "naturel", or items 23s or 28s-f show the Medical Examiner must be not red at 1 X Yas 2 No Directo BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1916 W. FRANKLIN STREET. 21223 USA Funeral filed within 72 hours efter death Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 12. Was Dacedant Evar in U.S. 11. Marital Status Armed Forces? 1 Yas 2 No If Yas, Giva 1 ☐ Never Marriad 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: AFRO. AMERICAN by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 42-43 Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 end 2 should be filed within 7 Department of Health end Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Mental page. Collega (1-4or 5+) Elamantary/Secondary (0-12) EASTERN STAINLESS STEEL 12 WORKER 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) WASHINGTON MARTHA WASHINGTON 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 1916 W. FRANKLIN STREET, BALTIMORE, MARYLAND 21223 LILLIE WASHINGTON WIFE 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 ☐ Othar (Specify) GARRISON FOREST V.A.CEM 7/31/98 OWINGS MILLS, MD. LLOYD 21. Signature of Funaral Sarvice Licansas 22. Name and Addrass of Facility ESTEP BROTHERS FUNERAL SERVICE, P.A. ESTER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heave failure. List only one cause on each line. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximata Intarval Batwaan Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical a. Tongue Concer Dua to (or as a consequence of): Examiner Physician/Medical Examiner Multiple myeloma Saquantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaguance of) Division of Vital Records, P.O. Box 687 Dua to (or as a consequence of): The law requires that the damm Part II. Other significant conditions contributing to death but not resulting in the underlying couse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown chronic rend insufficions, COPD, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed After this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: Be 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 PRasidance 6 Other (Specify) ို To the Hospital or Attanding Phy within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral of Certification: 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifiar 29b. Signatura and atla of certifiar 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) 315 N. Calvet Street Baltimore MD 01202

Registrar **DHMH 16 Rev 6/95**

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31. Data filad (Month, Day, Year)

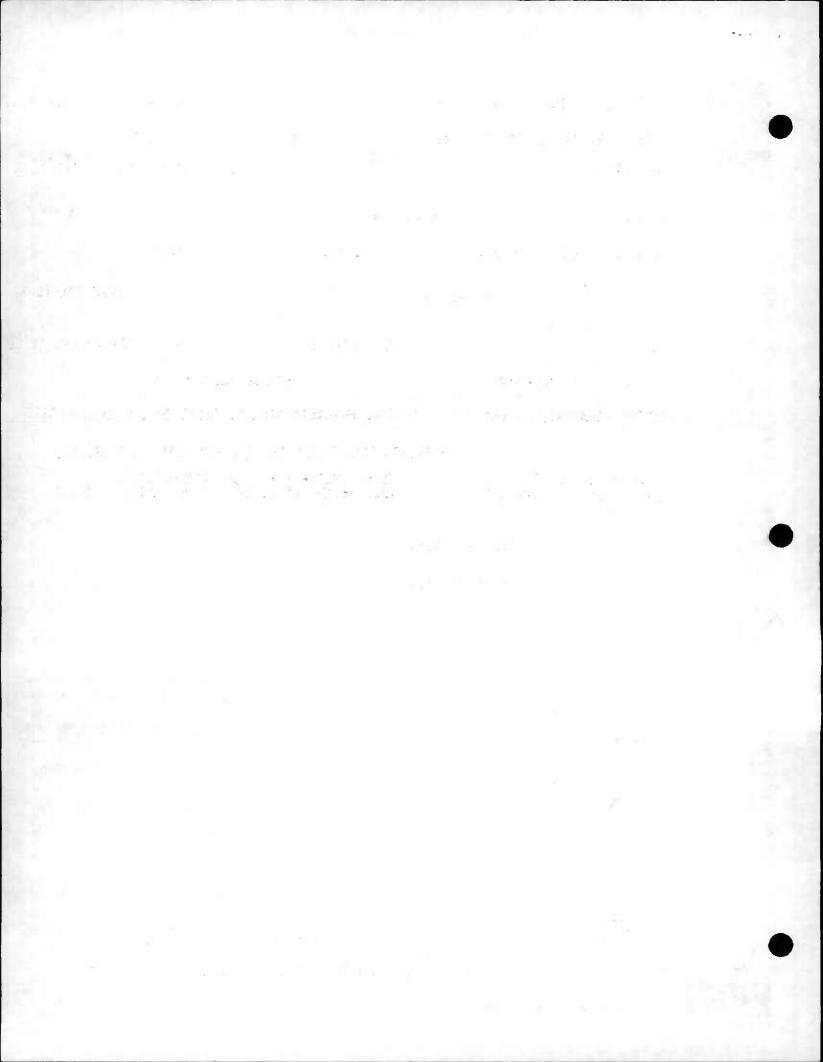
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K.D.

32. Registrar's Signatura

Sia Davidson

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month :10am WESTREICH TUL 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth HOSPITAL IMORE BALT N/A If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 8. Dete of Birth (Month, Dey, Yeer) Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthday) Deys Hours XXM 2 F Yrs. 078-18-8951 DEC. 23, 1923 NEW YORK Usuel Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2410 SMITH AVENUE 21209 U.S.A. 12. Wes Decadent Ever in U,S. Armed Forces? AXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 Married WWII 1 ☐ Yes XXNo Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) DISTRICT MANAGER PEP BOYS STORE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) LEO WESTREICH RUTH GOODFRIEND 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ELAINE WESTREICH (WIFE) 2410 SMITH AVENUE BALTIMORE, MD 20b. Placa of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7/29/98 BETH TFILOH CEMETERY BALTIMORE, MD 4 □ Donetion 5 □ Other (Specify) neture of Funeral Service Licens 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 nter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiac or respiretory errest, r heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final diseese or condition resulting In deeth) · Massive intracerebral hemorrhage Due to (or as e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that inItleted events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequença of): 23b. Did tobacco usa contribute to the causa of death? Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 4 Unknown 1 Yes 2 No 3 Probably 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 Tyes 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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permit. Pegas 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be in the different

altimore, Maryland 21215-0020

Physiclan/Medical Examiner by Completed diractor Be 2 Certification:

been signed by tha should be deteched s cartificate her diractor, pega 2 or Attending Physician: this funaral Aftar eftar daath. Director: Af To the Hospital or Atterview within 24 hours efter day To the Funeral Director completely filled in by the

Division of Vital Records, P.O. Box

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deat 1 Neturel 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of cartifier

29a. Certifier

(Check only one)

edical

29c. License number

29d. Date signed (Month, Dey, Year)

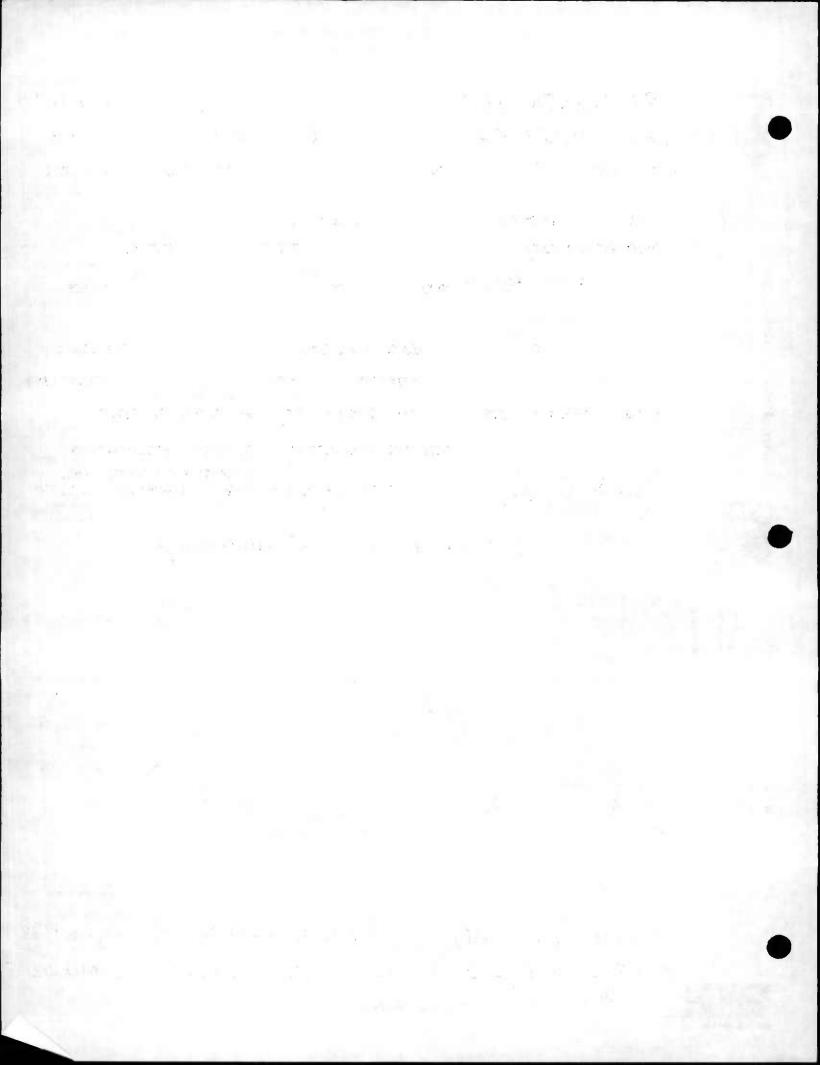
M 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

AS2402321 PK9200 July

2401 W. BELVEDERE AVE. BALTIMORE MO 21215 HUSPITAL

State Registrar





State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 4:00 a.m. Patricia Ann Anderson July 12, 1998 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3804 Parkwood Street Brentwood Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1□ M 2⊠ F Yrs. Director 579-34-6172 66 Jan. 26, 1929 Pennsylvania Usuel Residence of Decedant the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or frems 23a or 28a-f show other traumatic event, its Medical Examinal must be notified at 1 K Yas 2 □ No Directo Maryland | Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3804 Parkwood Street 20722 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercise apple. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 🗓 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Saxon Thornton Anita 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Paula L. Smith - Daughter 6610 Placid Street, Falls Church, Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/98 Metropolitan Crematory Alexandria, Virginia 21. Signature of Egneral Service Licansee 22. Name and Address of Facility Gasch's Funeral Home lons 1as 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 2rraythm/ Examiner Due to (or as a consequence of): Examiner the buriel-transit ON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events and Due to § P.O. Box 68760, attending physician for use as the burie (or as a consequence of) death certificete be Physician/Medicai resulting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 6 1 Yss 2 No 3 Probably 4 Unknown signed b by been signated 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 200No 1 Yes 1 ☐ Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) in by 4 Homicide e Hospital on 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the P within 2 29b. Signature and title of pertition 29c. Licanse numbar 29d. Data signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr ,521 Elm Ave., Takoma Park, MD 20912 Tra 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Stella Alexander Emma July 1998 12:30 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Rising Sun If Under 24 Hrs. Calvert Manor Healthcare Center Cecil 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) 1□M 2\ F Deys Hours Months Min. 83 1914 213-16-9673 Maryland Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maryland Cecil North East 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 785 Howery Lane LISA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indlen, Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) Seamstress 8 Sewina Factory 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) John A. Ragan Maryland Moore 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jean Howery/Daughter 785 Howery Lane North East, MD 21901 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) wokview Cemeteru 7-20-98 Rising Sun, Maryland R. I. Foard Funeral Home, P. A. 111 S. Queen St. Rising Sun, MD 21911 21. Signeture of Funere Service Ligarita Entry the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, near failure. List only one cause on each line. immediete Ceuse (Finei diseese or condition resulting in deeth) CEREBROVASCULAR ACCIDENT 3 MONTHS Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE LUNG DISEASE

Physician /Medical Examiner

certificate be executed

Physician

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pernit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at

ettanding physician end if for use as the buriel-transit

Physician/Medical þ Completed Be

Records, P.O. Box 68760, certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

> State Registrar

24b. Were eutopsy findings evalleble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yee 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier

Medical Examiner: On the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted.

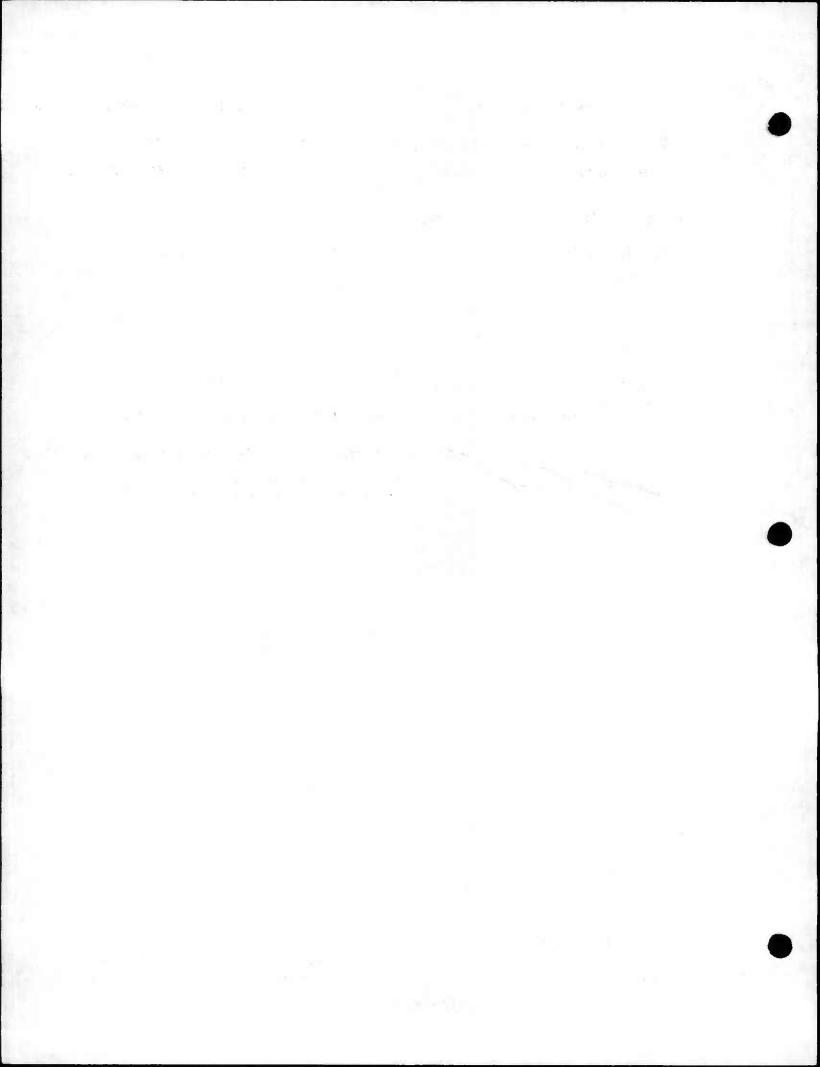
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. 29c. License number 29d. Dete signed (Month, Dey, Yeer)

29b. Signature and title of certific allyanny

30. Name end endressed person who completed cause of deeth (Item 23e) (Type, Print)

terryville Md. 21903 HANJAN 1 181

32. Registrer's Signeture while Davidson-Randoll



State of Maryland / Department of Health and Mental Hygiene Q Amend: #7 Per MD Film G761 7-30-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Randall James Wilson Albin 1998 01, 3:30 PM JULY /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Saint Joseph Medical Center H Under 1 Yeer | H Under 24 Hrs. 8. Dete of Birth (Month) Day, Pear)

Months Days Hours Ming (Month, Day, Year)

Minutes July 1, 1998 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs Maryland Director Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-1 show the Medical Examiner must be nothed at 1 ☐ Yes 2 ☐ No Cockeysville Director MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 606 A Clovercrest Way 21030 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 Never Merried 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Şecondery (0-12) College (1-4or 5+) n/a n/a other permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, important: If item 27 is marked othe any Injury or other traumatic event, pine. 17. Fathar's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Randoulf James Wilson Albin Melissa Ann Johnson Randoulf J.W. Albin/Father Melissa A. Johnson/Mother 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 606 A Clovercrest Way, Cockeysville, MD21030 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State Stablers Cemetery 11998 4 ☐ Donation 5 ☐ Other (Specify) Parkton, MD 22. Nama end Address of Fecility 21: Signature of Funeral Service blo J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 0 MAN 23a. Pert1. Enter the disease, or complications that call ed the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause in each line. Approximata Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) MINUTES /Medical EXTREME PREMATURITY Examiner Due to (or es e consequence of): edical Examiner attending physician and for use as the burial-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760, thet initieted events resulting in death) Lest Due to (or es e consequence of) Physician/M P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 25 No certificate Vital Hospital or Attending Physician: 24 hours after death. director Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yes 20€No Medicai Certification: To Division of this 28c. Injury et Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Aftar 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide within 24 hours aft To the Funeral Di completaly filled in TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the 29b. Signatura and title of certifier 29c. License number 29d_Date signed (Month, Dey, Year) 16/ D Ø1927 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 7620 YORK ROAD, TOWSON, WILLIAM DEVOE, M. D. . 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State JUL 3 0 1998 Julia Saindson Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month JULY 4c. County of Death LOUISE BROOKS 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) PRINCE GEORGES SOUTHERN HOSPITAL MARYLAND CLINTON If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number Days 1 □ M 20 F 91 249-12-1042 8-5-1906 NEWBERRY, SC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Insida City Limits 1 Yes 2 □ No PRINCE GEORGES CLINTON 10g Citizen of What Country? 10e Street and Number 10f Zin Code 9211 STUART LANE 20735 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 6th DOMESTIC 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Father's Name (First, Middle, Last) **JAMES** GALLMAN UNKNOWN 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 800 SOUTHERN AVE., SE #902 WASH.DC 20032 LISA GIBSON-GRANDAUGHTER 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 17-98 BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica License 22. Nama and Addrass of Facili FUNERAL HOME TAYLOR'S 1722 NORTH CAPITOL ST., NW WASH.DC 20001 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 25a. Part1. Enter the disease, or o shock, or heart feilure. List of Immediate Cause (Final . HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consaquanca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to 24e. Was en eutopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner 1 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3□ DOA 1 🗆 inpatiant 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending 1 Natural 1 ☐ Yes 2 ☐ No **∠**□ Accident Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and makiner stated.

3001 HOSPITAL

29c. License number

PRIVE,

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

CHEVERLY, MARYLAND

The law requires that the death certificete be executed pue has Physiclan: or Attending death.

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Director

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Certification:

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filed within 72 hours efter

Baltimore, Maryland 21215-0020

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State Registrar

30. Name and address of person who

31. Date filed (Month, Day, Year)

32. Ragistrar's Signature all developed

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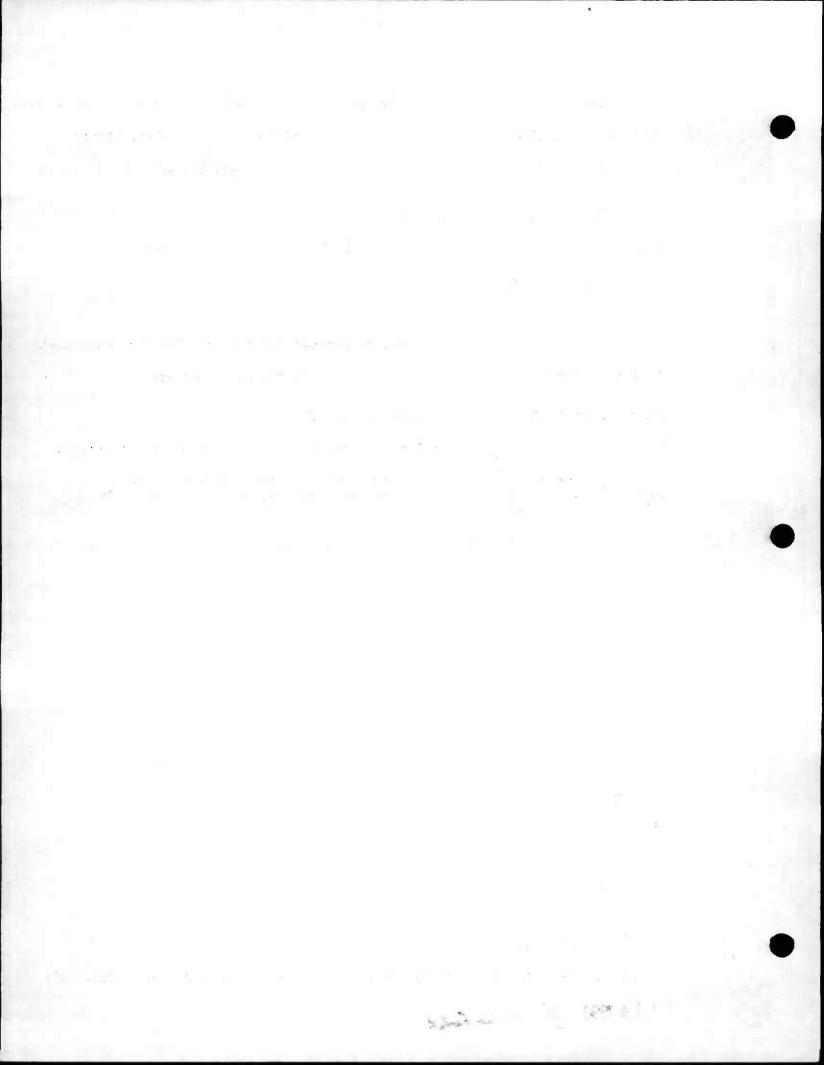
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Funeral Director	5. Sociel Security Number 6. Sec. 577–34–4928	7. Age (II 73 73	(In yrs. lest birthday) Yrs. If Under 1 Year Months Deys Hours Min.			lin. (Month, D	irth ley, Year) 9, 1924	9. Birthplece (State or Foreign Country) Washington, DC					
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23a or 28a-f s ust be notified al Director	10e. Street end Number 9806 Glen View D	r.		10f. Zip Cod 207			10g. Citizen of Whet Country? USA						
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certificate has rector, page 2 b Be Comp						1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No					
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5)	30. Name end eddress of person who	mpleted cause of deet	(Item 23e) (Type	DO Print)	7348	>	July	13.1997					
)/	Robert M. Nedzb				n Rd.#101	l, Ft. Wa	shingtor	, Md. 20744					

Jahn Davides Rayfall

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Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Physician WINNIE L. BYERS July 10,1998 4:55 A.M. /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number If Undar 1 Yaar Months Days 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□ M 2X F 58 213-40-7166 Director 1/40 Wash., D.C. Usual Rasidence of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show Examinar must be notified at Md. P.G. Capitol Hgts. Director X Yas 2 No 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 'natural', or Items 23a or 7311 ShadyGlen Terr. 20743 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, White, atc. 13. Was Decedant of Hispanic Orlgin? (Spacify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, etc.) 1 Navar Marriad 2 Married 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: 1 ☐ Yes 2 ☒ No Spacify: Black Specify: þ 3 ☐ Widowad 4 ☐ Divorced Completed 15. Dacedent's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry end 2 should be filed within ealth end Mental Hygiene. n 27 is merked other than Elementary/Secondary (0-12) Collage (1-4or 5+) yr. Homemaker Own Home Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be 2 John Dickens Minnie Durham 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 end 2 s
Department of Health er
Important: If item 27 is
any injury or other trau Same as # 10 above Henry L. Byers, Jr./Husband 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Harmony Mem. Park 7/20/98 Landover, Md. 21. Signatura of Funaral Sarvica Licansaa

22. Name and Addrass of Facility

H.S. Washington & Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C.

23a. Part1. Enter tha disaase, or complications that caused the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest,

Approximate Internal Sarvica Licansaa Approximata Intarvat Batween Onset end Death **Physician** Immadieta Ceuse (Finat disaasa or condition resulting in daath) /Medical gram negative **Examiner** Distress Syndrome Physician/Medical Examiner Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disaase or Injury buriei-tre Box 68760. thet initiated avants rasulting in daath) Last the for P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting leshrectomy a tartia 1 Yas 2 No 3 Probably 4 Unknown Records, by diffuse alveolor Completed 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to damage it both complation of causa of deeth? Diabetes mellitu The 1 ☐ Yes 2 No of Vital Be 25. Wes casa referred to medical exeminar? 26. Placa of Daath (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA 1 Yes 2 No Othar: 4 ☐ Nursing Homa 5 ☐ RasIdance 6 ☐ Othar (Specify) Certification: To this funeral 27. Manner of Daath 28c. tnjury at Work? 28d. Describe how injury occurred After Division Attending ours effer dean. 1 Natural 2 Accidant 5 Pending Invastigation 1 Yas 2 No 6 Could not be datamined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Route Numbar, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Scertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) and menner es steted.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated. edical 29a. Cartifier 29b. Signature and titla of certifian 29d. Data signed (Month, Day, Yaar) 29c. Licansa number KARE TERWILLIGER, M.D. 31. Date filad (Month, Day, Year) State Registrar

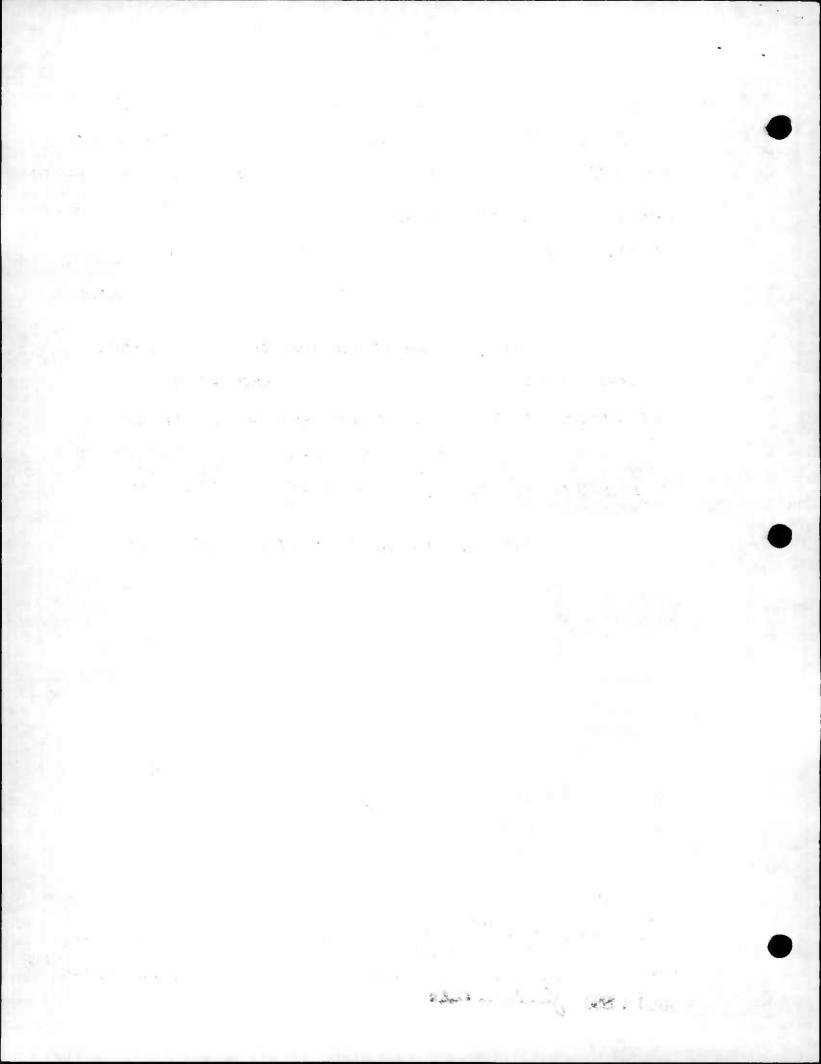
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** 14, 3:06 a.m. Sarah C. Chen July /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2♥F Months Days Yrs. Director 060-50-5937 60 12, 1938 Taiwan Usual Residence of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or fiama 23a or 28a-f show and fujury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland| Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9015 1st Street U.S.A. 20706 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ¹ Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Asian à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Rental Housing 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 0 Unknown Unknown 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Kevin Chen - Husband 9015 1st Street, Lanham, Maryland 20706 20b. Place of Disposition (Nama of cematary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 【Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/18/98 Alexandria, Virginia 21. Signature of Funaral Service Lin 22. Name and Address of Fecility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death polymicus Gial sepsis / septic shoch Physician 2 days Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or as e consequence of): fistula Kecto vesical attending physicien and for use as the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or injury Dua to (or as a consequence of): Radiation enteritis P.O. Box 68760. iclan/Medical that initieted events resulting in death) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contributa to the cause of death? Phys abdominal Savcoma 2 No 3 Probably 4 Unknown 1 Yes Records. p 24b. Wera autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 TYes 2 No this certificate Division of Vital Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifical ielely filled in by the funeral director, i 25. Wes case raferred to medical Be 26. Place of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 9 28c. Injury et Work? 27. Mennar of Death 28b. Tima of 28d. Describe how injury occurred edical Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end mannar steled. 29a. Cartifier To the To the To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier selouil, cu.o. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Annapolic, Md. 21401 5 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last-2. Dete of Death Physician Lerou /Medical 10/1 Mandat institution, give street end number) Lecation of Death Examiner County of Deeth Age (In yrs. last birthday) 5. Sociel Security Numb 217-12-1339 ,Funeral 9. Birthplece (Stete or Foreign 8. Date of Birth (Month, Dev. 11XM 20 F **Director** MARCH 10,1921 UPPER MARLBORO Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at MD PRINCE GEORGES SUITLAND Director ¥XYes 2 No 10e. Street end Number 10f. Zin Coda 10g. Citizen of Whet Country? 2014 GAYLORD DR. 20746 UNITED STATES Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: by 1 ☐ Yes XXNo Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOREMAN P.G. COUNTY PUBLIC WORKS 8 permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event since. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be WILLIAM CHAPMAN MAUDE BUTLER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) FRANCES CHAPMAN/wife 2014 GAYLORD DR. SUITLAND MD 20746 20b. Piece of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Data 1 Burlal 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) RESURRECTION CEMETERY 7-15-98 CLINTON, MD 21. Signatura of Funerel Sarvice Licansae 22. Nama and Address of FecilityALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE ,MD 20747 ARR mons 23e. Per 1. Enter the clause, or complications that caused the deeth. Do not anter the mode of dying, such es cardlec or respiretory errest, shock, or hear failure. List only one ceuse on eech line. Approximete intarval Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probabiy 4 □ bnknown by Completed 24b. Were eutopsy findings evelleble prior to complation of causa of deeth? 24e. Wes en eutopsy performad? 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 Yes 2 Accident 6 Could not be determined

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Data signed (Month, Dey, Year)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attanding Physician:

physician

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certificate

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Items 23a

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"natural",

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filed within 72 hours after

21215-0020

Baltimore, Maryland

To the Hospital or A within 24 hours effer to the Funeral Direc completely filled in by

State

edical

31. Dete filed (Month, Dey, Year)

ABULHASAN

29b. Signature end titla of certifier

32. Registrar's Signeture

ANSAL

30. Neme end eddress of person who completed cause of deeth (Itam 23a) (Type, Print)

14.1998 Registrar

3 ☐ Sulcide

4 - Homicida

(Check only

28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the tima, dete end pleca, end due to the ceuse(s) end menner steted.

29c. Licansa number

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	Certificate of Death 1. Decedent's Name (First, Middle, Last)							Reg. No. 90 2328					
Physician									Month	Day	Yeer	Time of Death	
/Medical		T LEE CLA					4 65 7		July			2:57 PM	
Examiner		(If not institution, give :							cation of Death	,		77.0	
	1613 FENWOOD AVENUE					Williada d Mar	OXON				E GEORG		
Funeral Director	5. Social Security I	152 ¹ X	M 2□ F	61	yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			Min.	8. Date of Birt (Month, De Jan 3,	1937	9. Birthplace Country) North	(State or Foreign	
yland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											Inside City Limits	
a-f-s	Maryland Prince Georges Oxon HIII										1	1 Yes 2 □ No	
vith the Ma or 28a-f s be notified	2 10e. Street and Number 10f. Zip Code									10g. Citizen of V	Vhet Country?		
th will	1613 Fenwood Ave. 20745									United	States		
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ant, the Madical Experience must be notitled at any the Madical Experience must be notitled at	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:						f Hispanic Origin? (Specity Yes or No- uban, Mexican, Puerto Rican, etc.) Specify:			Blac	e - Americen Ir ck, White, etc.	ndien,	
"natural", adical Ex-	10	15. Decedent's Edu		16a	16a. Decedent's Usuel Occupation					16b. Kind of Business/Industry			
be filed within 72 hor tal Hygiene. d other than "natura event, the Medical Be Completed	(Spe	ecify only highest grede	College (1-4or 5-	4)	life. D	ond of work do ONOT use ret	ne during most ired)	of work	ng				
y with	12th		College (1-401 3		s Dr	iver		Prince Georges County					
ent,	17. Father's Name	(First, Middle, Last)					18. Mothe	r's Name	me (First, Middle, Meiden Surneme)				
Mental Mental Mental Merked artic ev	James C	lark					Luel:	la A	nthony				
should be and Mental marked o umatic ev	19a. Informant's N	Name/Relationship (Ty	pe. Print)	198	o. Mailine	Address (Stre				er, City or Town,	Stete, Zip Coo	de)	
and 2 seeith ar n 27 is	Mary C1		Wife							Marylan			
permit. Pages 1 and 2 should be filed withir Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mente.	20a. Method of Dis		WILE	20b. Place o	of Dispos	ition (Neme of		OAOII	Date	20c. Location -			
Pages 1 tent of Hi nt: If iten iry or oth	1 Burial 2	Cremation 3 □R	emoval from Stete	cemete	ny, crem	etory or other p	olece)	1	1 1				
permit. Pa Departmer Important: any injury		5 Other (Specify)		Harmon	4	emorial	Park dress of Fecility		/15/98	Landov	er, Md.	,	
ing physician end ing physician end ing physician end ingresse as the burial-transit	23a. Part1. Enter shock, or he limmediate Ceuse disease or condition resulting in death) Sequentially list of any, leading to icause. Enter Und Cause (Disease other initieted even resulting in death)	conditions, immediate berlying or injury	. My	the death. Do	consequence consequence	in the mode of of the control of the	tying, such as	cerdiac (e u	rrest,	Ap	nd 20747 proximate erval Between set and Death	
death cer e attendin d for use	Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.							23b. Did tobacco use contribute to the cause of death?					
as that the death cer gned by the attendir be detached for use by Physician/N	Take to see a symmetric continuous continuous to death out not resouring in the underlying couse given in Fait I.							1 Yee 2 No 3 Probably 4 Unknow					
requira									en eutopsy prmed?	evailab	eutopsy findings ble prior to etion of ceuse th?		
The late has page									10	Yes 2 No	1 □ Ye	s 20 No	
sician: The law certificate has b lirector, page 2 s	25. Was cese refe	erred to medicel					26. Plece	of Deat	h (Check only	one)			
or Attending Phy after death. Director: After this in by the funeral of ertification: T	27. Manger of Death 1 Neturel 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 3.								g Home 5 Residence 6 Other (Specify) 28d. Déscribe how injury occurred				
								28f. Location (Street end Number or Rurel Route Number, City or Town, State)					
To the Hospital within 24 hours of To the Funeral I completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es steted. Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.												
within to the comple	29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)									Year)			
111	1	Dan ne	1 well	ollia	~	D	149	23		7-1	3 - 98	5	
(13)	30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) BRACALKOTKAR 3611 Branch Are Temple Hulk MD 26748												
0	BRDA	+CALKO-	TKAR	3611	(Stanc	h Ho	e	iempi	26	748		
State Registrar	31. Date filed (Mo	nth, Day, Year)	32. Registra	ar's Signature				e-					

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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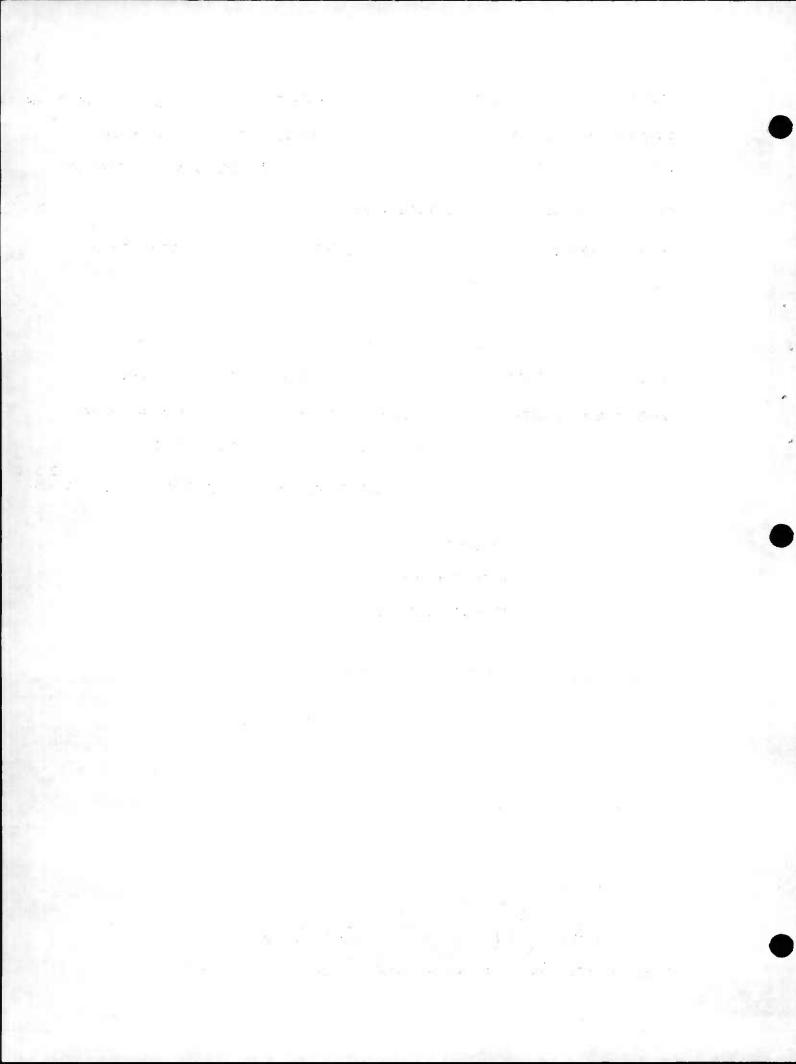
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 Month 01 CASTLE 98 **Physician** COLTON TYLER 08:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** ALLEGANY CUMBERLAND SACRED HEART HOSPITAL Hours Min. 8. Date of Birth (Month, Dey, Year 01 23 98 If Under 1 Year Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Year 10XM 2□ F Yrs. Director NONE Usual Residence of Decadent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show billion Examiner must be notified at LITTLE ORLEANS 1 ☐ Yes 2 No MD ALLEGANY Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21766 UNITED STATES 13101 MANN ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA NA NA NA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be **BRENDA** LOUISE MANN CASTLE MICHAEL JUNIOR 2 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rure! Route Number, City or Town, Stete, Zip Code) MANN ROAD LITTLE ORLEANS MD 21766 BRENDA CASTLE - MOTHER Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-23-98 HANCOCK, MD PINEY PLAIN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21502 DECATUR ST. CUMBERLAND, MD KIGHT FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Niedical PREMATURITY Examiner Due to (or as e consequence of): Physician/Medical Examiner PRETERM LABOR The law requires that the death certificate be executed physician and sthe burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) POSSIBLE CHORIOAMNIOITIS P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) 89 use es for u signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? been sig 24a. Was an autopsy performed? Completed s certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. director, Be 25. Was case referred to medical 26. Piace of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending investigation 1 Naturai Injury 1 Yes 24 No 2 Accident Director: / 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di complately filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Dev. Year) 29b. Signature and title 29c. License number 30. Name and address of person who comp eted cause of death (Item 23e) (Type, Print) CUMBERLAND, MD 21502 DEBBIE FORNWALT RN 900 SETON DRIVE

State Registrar JL 30

31. Date filed (Month.

32. Registrar's Signature Randell who Davidson

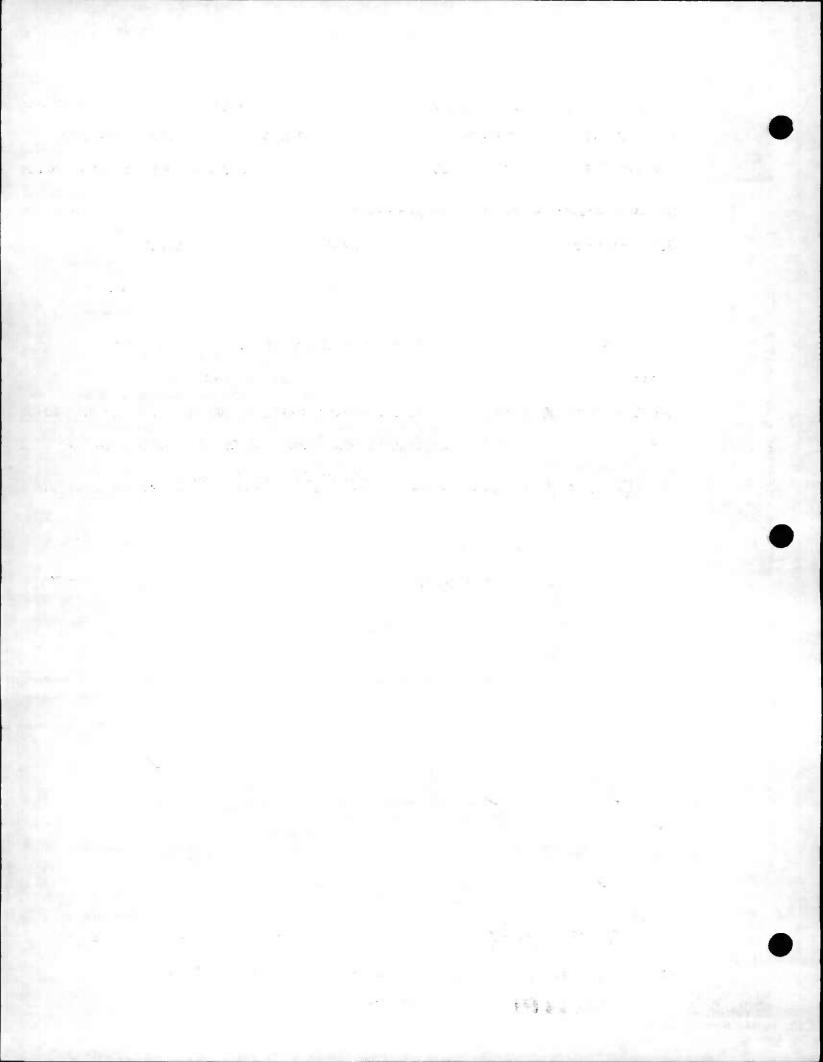


State of Maryland / Department of Health and Mental Hygiene 🔾 🔿 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Dey **Physician** 12, 12:25 AM SADIE BELL MACK DARBY July 1998 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Southern Maryland Hospital Clinton Prince George's Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year)
May 29, 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 X F 251-56-1555 Yrs 63 South Carolina Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits nal Hygiene. Id other than "natural", or itams 23s or 28s-f show event, the Ned cal Examinet must be notified at Maryland Prince George's Temple Hills 15 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? with 3511 Chadwick Court 20748 U.S.A. death v Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) pernit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or ital mortant: if item 27 is marked other then "natural", or ital mortant in living or other traumatic event, the Medical Evantical page. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: P 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Private Licensed Practical Nurse 12th 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unknown Martha Mack 20 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Douglass Darby Jr/Husband 3511 Chadwick Court, Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from State Maryland Veterans Cem. 07/20/98 Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 haves of Downer 23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel O. CONGOSTINO HEADY FRILURE 4.eaus disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner 5/Low CARDIO MYEDNYA and I-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) physician ar Box 68760. Physician/Medicai Due to (or as e consequence of): 98 ettending p for use es signed by the e 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? been si 24a. Wes en eutopsy performed? Completed page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: director, Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this After this funerel of 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? Certification: or Attending 1 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homlcide To the Hospital on within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a Certifier 29d. Date signed (Month. Dev. Year) 29c. License number 29b. Signature end title of certified DO .7347 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) AN FORT WASK, Mel 20144 11761 LIVINGE +cm RIM-NEDZBALX. 32. Register's Signeture

Julia alturulum Randall 31. Dete filed (Month, Day, Year) State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Daath Month **Physician** etolia Ellis 9:36 AM July 1998 /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince George's Hospital aurel Laurel If Under 1 Year Months Deys 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Yaar) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 22 F 5 223-38-1041 Feb 26,1913 Virginia Director Usuel Residence of Decedant the Maryland 10a. Stete 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 10d. insida City Limits 1 ☐ Yes ZW No Director Hyattsville ince 10e. Street end Number 10f. Zip Code 10a, Citizen of What Country? death with 5665 U.S 20787 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bieck, White, etc. 11. Maritei Status 1 Never Married 2 Married 1 ☐ Yes 2 € No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Specify: Black δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Retired Seamotres permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, 2008. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be horles 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 19a. Informent's Neme/Relationship (Type, Print) Sargent Rd Hyattsville Md 20782 lillery 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Crametion 3 □ Removel from Stete 7-11-98 enetry Alexandria, Va 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funarei Service Licensee 22. Name end Address of Fecility Alex, VA. 22313 25813 23a. Pert1. Entar tha disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or haart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediata Cause (Finel disease or condition resulting in daath) /Medical Sepsis (tours **Examiner** Due to (or es e consequence of): Examiner neumonia ed by the ettending physician end deteched for use es the bunal-transit Sequentially list conditions, if eny, laading to immediate ceuse. Enter Underlying Causa (Diseese or Injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, 8 Physician/Medical thet initieted events resulting in death) Last Dua to (or es e consequence of) Pert il. Other significant conditione contributing to death but not resulting in the underlying ceusa givan in Part i. 23b. Did tobacco use contributa to the causa of death? po thermic 1 Yes 2 No 3 Probably 4 Unknown þ ed bluods 24b. Ware autopsy findings aveileble prior to completion of cause of death? ongestive Heart Fallure Completed 24a. Wes en eutopsy peen After this certificate hes 1 No 2 No 1 ☐ Yes 2 No Be 25. Wes cese raferred to medicel axaminer? 26. Plece of Daeth (Check only one) Hospital: ↑ Inpetient 2 □ ER/Outpetient 3 □ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yes 2 No 2 filled in by the funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred 5 Panding investigation Naturel death. To the Hospital or Attendition within 24 hours efter death.

To the Funeral Director: A completely filled in by the form 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida 29a, Certifian 1 Certifying Phyeicien: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daeth occurred et the time, dete end place, and dua to the cause(s) end manner stated. Medicai (Check only one) 29b. Signature end title of certifiar 29c. License number 29d. Pate signed (Month, Dey, Year)

Balhmore Ave Laurel MD 2070

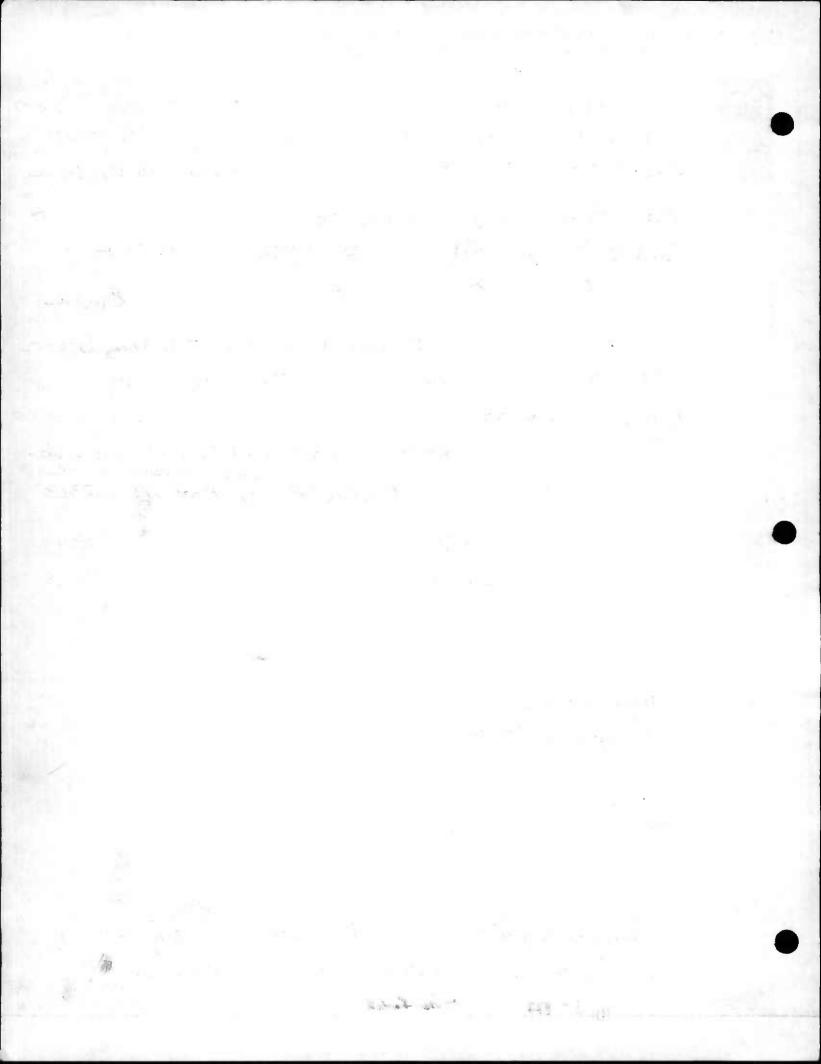
State Registrar 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

13952

32. Registrer's Signatura

Jenny Y May

31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yee Month CATERINA ADAMO July 98 11:49AM 12 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and nu 4c. County of Death Prince George's Clinton Southern Maryland Hospital Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) July 5, 19 5. Social Security Number 6. Sex Days Hours 1□ M 2□ F Months 1907 092-30-0766 Italy Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 No Yes 2 No Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 7616 Bock Rd. IISA Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 3 At Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cesare Trunzo Maria Costanzo 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lina Privitera/Daughter Same as item 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation Wither (Specify) Entompment Resurrection Cem. Mausoleum 7/15/98 Clinton, Md. 22. Name and Address of Facility
George P. Kalas Funeral Home also 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Approximate Interval Between Onset and Death Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Tda disease or condition resulting In death) Due to (or es e consequence of): Deydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 TYes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mertal Hydione. Department If them 23 a or 28e-f elbow important. If them 27 is arrived other than "natural", or items 23a or 28e-f elbow any injury or other traumatic event, the Medical Experiment must be notified as

Baltimore, Maryland 21215-0020

physician and s the buriel-trans ettending p been signed by the e should be deteched page 2 certificate director, this

s efter dec. 24 hours e

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician:

To the Hosp within 24 ho To the Fune completely f

Medicai State Registrar

Physiclan/Medical Examiner þ Completed Be 2 Certification:

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

5 Pending

investigation

6 Could not be determined

31. Dete filed (Month, Day, Year) 32. Registrar's Signature JUL 13 1998 > Juli Davidear Randell

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

29d. Date signed (Month, Day, Year)

7-13-92

28c. Injury at Work? 1 Yes 2 No

28a. Date of Injury (Month, Day Year) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1045360

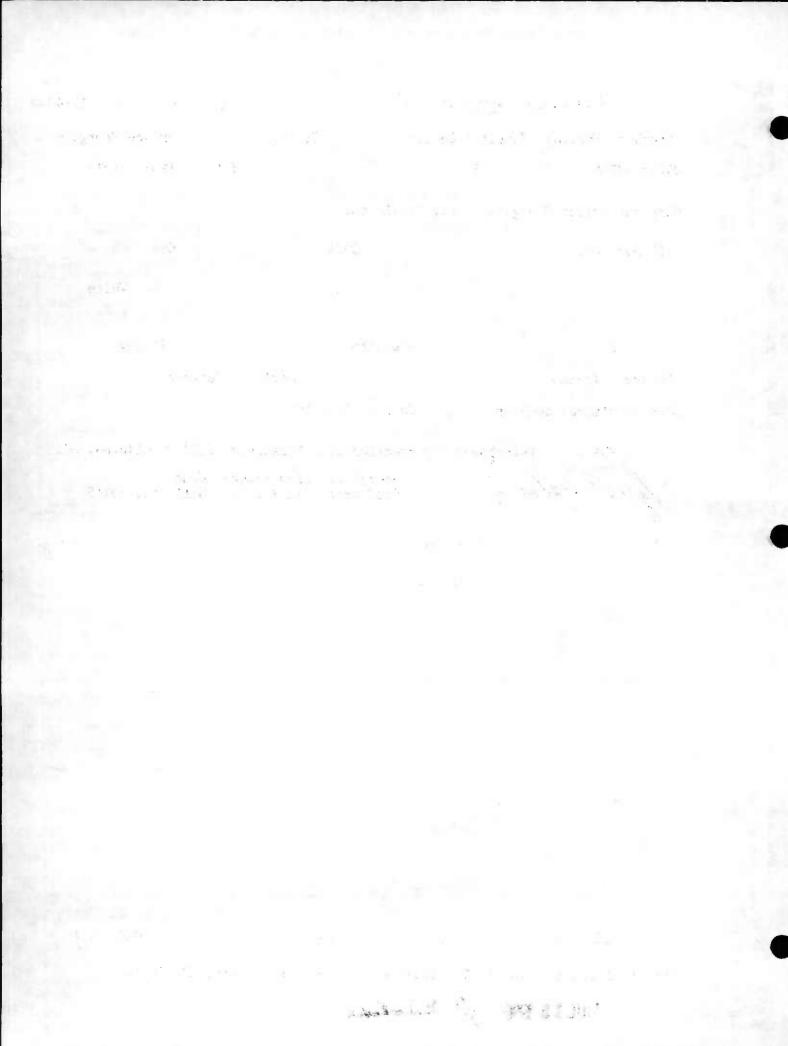
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Michael Sidarous, M.D. 11701 Livingston Rd. Ft. Washington, Md. 20744

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23286 Certificate of Death 3. Time of Death 2. Date of Death 9:06 pm. =11zabeth July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death (Jehera i HOS ambridge Dorchester If Under 1 Year Months Days 8. Date of Birth Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 10 M 21 F Days 585 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Maryland Of. Zip Code 10g. Citizen of What Country? 21613 USA reek 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0-12 None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Hlfred Dher llen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21613 Road Cambridge Mary Tand 305 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date Burlal 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State July 25, Mary Christ Rock, Mary land nrist 21. Signature of Funeral Service Licensee Funeral Cambridge Hubbard 23a. Part1. Enter the disease, or complications that ceused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death inter the mode of dying, such as cardiac or respiratory arrest. Immediate Ceuse (Final disease or condition resulting in deeth)

Physician /Medical Examiner

attanding physician end for use es the burial-trar

cartificata be axecuted

Division of Vital Records, P.O. Box 68760,

or Attending Physicien:

To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After thi completely filled in by the funeral

Physician

/Medical

Examiner

10a. Slale

Director

Completed by Funeral

Funeral

Director

'natural', or itema 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth and Mantal Hygiana. Important: If Item 27 is marked other than "natural, or item only injury or other traumatic event, the Muster Face once.

Baltimore, Maryland 21215-0020

traumatic event, the Mudical Examiner nust be notified at

Certification: To Be Completed by

Physician/Medical Examiner

27

Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

wo

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown

29d. Date signed (Month, Day, Year)

				24e. Wes en autopsy performed?	24b. Were autopsy indings available prior to completion of ceuse of deeth? 1 \(\text{Yes} \) 2 \(\text{No} \) No						
. Was case referred to medical exeminer?		26. Piace of Death (Check only one)									
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpetient 3☐	g Home 5 ☐ Residence 6 ☐ Ott	e 5 ☐ Residence 6 ☐ Other (Specify)							
. Menner of Death 1 Natural 5 Pending 2 Accident Investigati		28b. Time of injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred						
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not determine		nome, farm, street, fact	28f. Location (Street and Num. City or Town, Stete)								
Da. Certifier (Check only one) Certifying F Certifying F	hysicien: To the best of my known in the basis of examination and manner stated.	owledge, death occurre ation end/or investigation	ed et the time, date end pl on, in my opinion, death o	ece, and due to the ceuse(s) and m occurred at the time, date end place,	anner as steted. and due to the cause(s)						

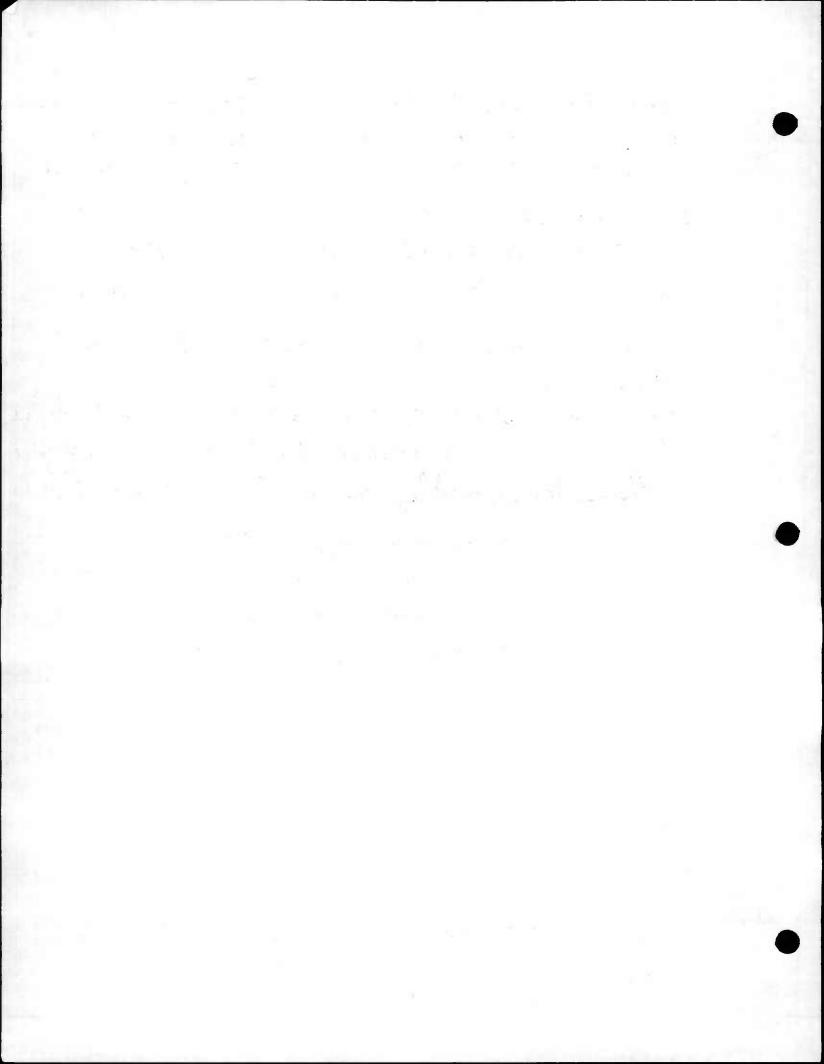
29c. License number

Registrar

edicai

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedant's Name (First, Middle, Last) Month **Physician** 06106 pm Leon Curtis Faircloth Jr. JULY 1998 08 /Medical 4e Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WALLACE BRENTWOOD PRINCE GEORGES 39116 ROAD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** 15€M 2□ F 245-60-5832 59 Yrs. Director Dec. 21, 1938 Washington DC Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumstic event, the Medical Examinal must be notified. 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland 1 Yes 2 □ No Prince George's North Brentwood Director 10e. Street end Number 10f. Zip Coda 10a. Citizen of Whet Country? 3916 Wallace Road 20722 USA Funeral 14. Raca - American Indien, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 X Yes 2 ☐ No If Yes, Give Yeer or Datas: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Government Supervisor 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Leon Curtis Faircloth Sr. 2 Virginia Beatrice Bailey 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rurel Route Number, City or Town, State, Zip Code) Mattie T. Faircloth/Wife 3916 Wallace Road, North Brentwood, MD 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete Buriel 2 Cremation 3 Removal from Steta Ft. Lincoln Cemetery 7/15/98 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Downso J. B. Jenkins Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate

Approximate harles of Intervel Batween Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition rasulting in death) /Medical . HYPERTENSIVE CARDIOVASCULAR DISEASE Examiner Due to (or es e consequence of): Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaasa or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): for use es signed by the e Pert II. Other efgniffcent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown DIABETES MELLITUS p 24b. Wara eutopsy findings eveilable prior to Completed 24a. Was en eutopsy performed? CHRONIC PANCKEATITIS completion of cause of daeth? is certificate has director, page 2 2X No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2□ No Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: A 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour.
The Funeral Dire.
The filled in by 4 - Homicida 29a. Certifier 1 Certifying Physicien: To tha bast of my knowledga, daath occurred et the time, dete end plece, end due to tha causa(s) and mannar as statad. edical To the Hosp within 24 ho To the Fune 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et tha tima, data end placa, and due to the ceuse(s) end menner steted. (Check only 29d. Dete signed (Month, Day, Year) 29c. License number DRIVE CHEVERLY MARIO HOSPITAL 31. Date filed (Month, Day, Year) State JUL 14. Registrar



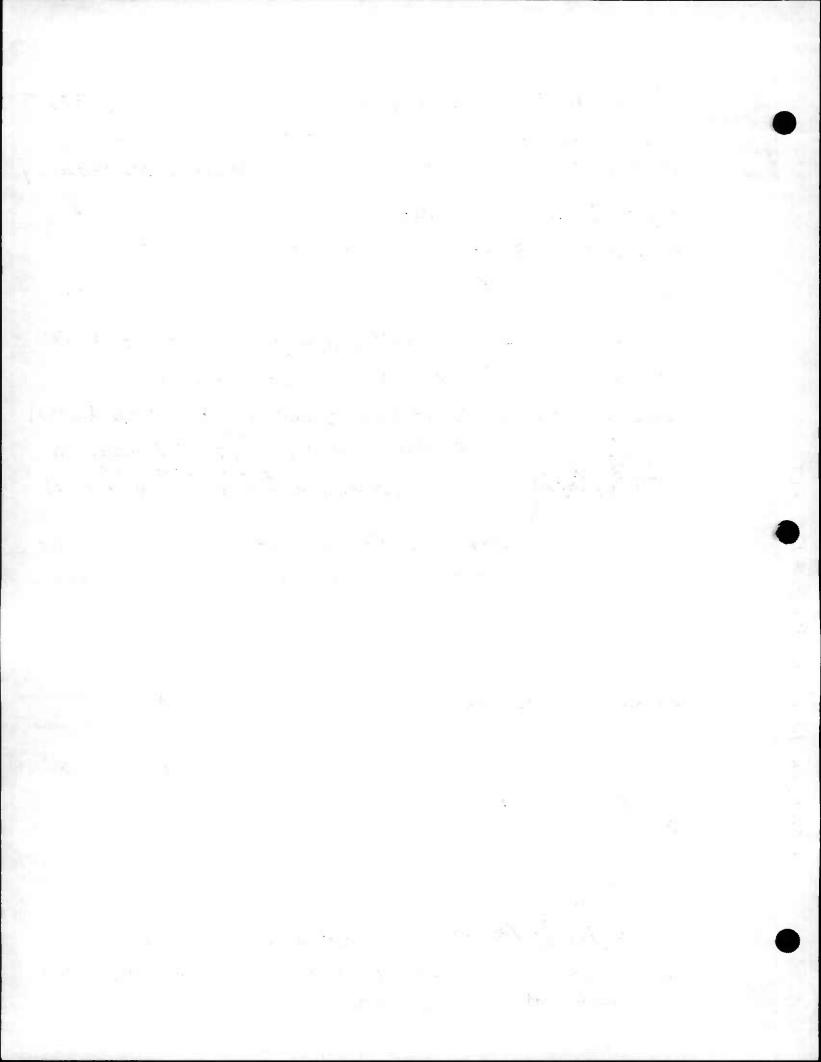
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23288 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death William Frederick Feldhusen **Physician** 1998 2215 vly /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street end number) **Examiner** Hospital Elkton Cecil Union If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months Days 131-07-0838 Yrs. September 26,1906 New Jersey Director Usual Residence of Decedent 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits recil Yes 2□No Maryland Elkton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 U5A 24 Walter Boulden Street Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other treumstic event, the Medical Examiner 1 Never Married 2 Married 21215-0020 Specify: White 6 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorcad 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Traffic Manager Fredstock, Inc. permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If them 27 is marked other any Injury or other treuments Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be William latherine Moran Feldhusen 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) er 24 Walter Bouken St. Elkton Maryland 21921 20b. Pleca of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State Joanne Zamesnik-daughter 20a. Method of Disposition 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State R.A. Ferris Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gee Funeral Home 259 E. Main St., Elkton, Maryland 21921 23a. Part1. Enter the ease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicai PNEUMONIA ASPIRATION 10 DAYS Examiner Physician/Medical Examiner EREBROVASCULAR ACCIDENT 1 YEAR requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of) Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PARKINSON'S DISEASE 24b. Were autopsy findings evallable prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate has 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 filled in by the funeral 27. Menner of Deeth 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how Injury occurred Natural 2 Accident 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be determined Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ HomicIde Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Yeer) wymu: MD 1)45344 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DHANTANI MD, 20 CRAIGTOWN RP, PERRYVILLE, MD 21903 SURESH

Aulia Davidson-Randalle

DHMH 16 Rev 6/95

State

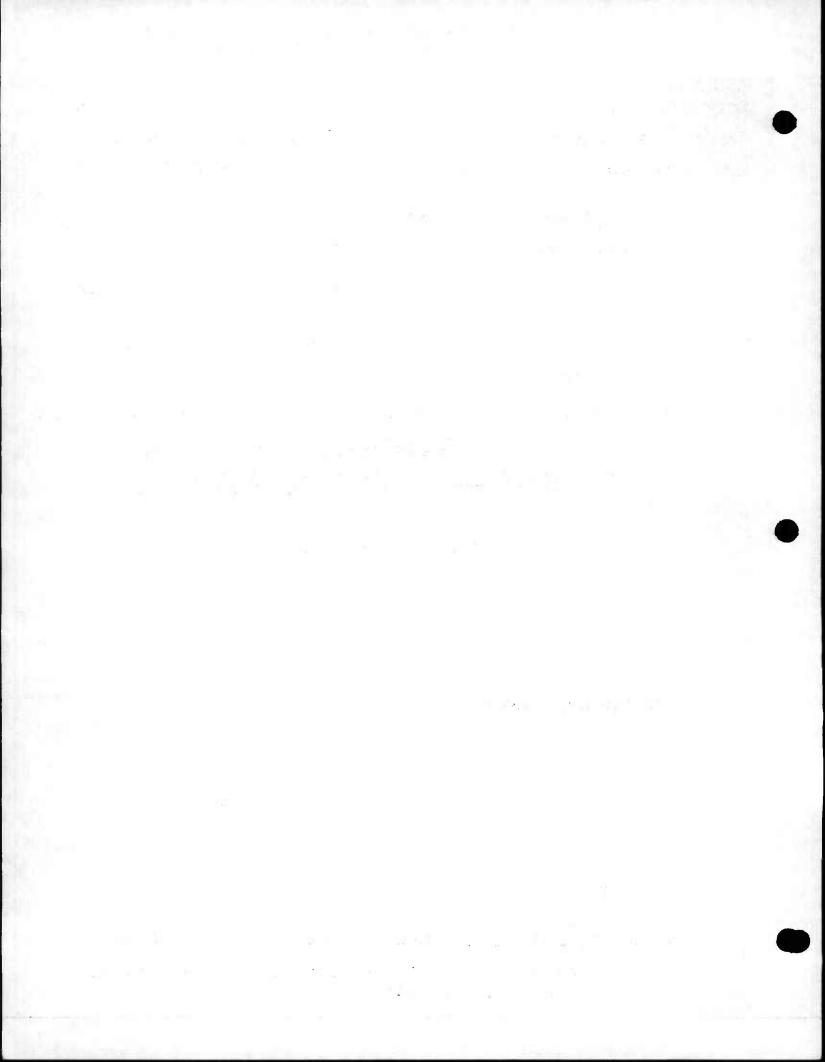
Registrar



State of Maryland / Department of Health and Mental Hygiene

98 23289

					Cer	tificate o	t Death		Reg. No.		. 0 2 0
Physicia		1. Decedent'e Neme (First, Middle, Li	est)				HEILT	2. Dete of Dec	eth Dey	Year	3. Time of D
/Medica		ORA GRANT						7	9	98	0730
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		520 PRISCILLA	ST				SALISBU	JRY	WICC	OMICO	
Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. le		if Under 1 Ye	er if Under 24 Hrs.	8. Dale of Birt	h v. Year)		ce (Stete or I
Director .		218-16-8053 Usuel Residence of Decedent	1□M 21∏F	79	Yrs.			April 1	7,1919		'VA
show talk		10a. Stete 10b. County		10c. City,	Town or Loc	cation				10	d. Inside City
23a or 28a-f shoust be notified at	runeral Director	MD Wicomic	00	Sal	isbur	У					1 X Yes 2
or 28	5	10e. Street end Number				10f. Zlp Code			10g. Citizen of \	Whet Count	ry?
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	2	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 A If Yes, Give Year or Dates:			Yes 2 X		o rican, etc.)	Specify	ck, White, e	
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Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", any injury or other treumatic event, the Medical Exa once.	o ne	17. Fether's Neme (First, Middle, Last George Stevensor						ne (First, Middle, Le Reed	Maiden Sumen	ne)	
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the	2	Part II. Other significant conditions	contributing to death I	oul not result	ing in the un	derlying ceuse	given in Pert I.	23b. Did 1	tobacco use co	ntribute to	the cause of
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00 0		1 X Yes 2 □ No 27. Menner of Deeth	1 Inpati	-	R/Outpetient	3LI DOA	4 Li Nuising r	lome 5X Resid)
The r	5	1 Neturel 5 ☐ Pending	(Month, De	y Year)	28b. Time of Injury		jury et Vork?	280. Describe i	now Injury occur	rea	
2 7 P	-	2 Accident Investigation	NO.	jury - At hom	ne, ferm, stre	M 1 eet, fectory, office	Yes 2 No	28f. Location (S City or Tov	Street end Numb	ber or Rurel	Route Numbe
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within 24 hours after death. To the Funeral Director: A completely filled in by the fi	anical	3 Suicide 4 HornIcide 6 Could not be determined 29e. Certifier (Check only one) 1 Certifying Plant (Check only one)	building, e	of my knowl of examinetic lated.	on end/or Inv	estigation, in m	y opinion, deeth occu	irred et the time,	date end place, 29d. Dete signe	end due to	the ceuse(s)
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State of Maryland / Department of Health and Mental Hygiene ()

	Director
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: If hem 27 is marked other than "natural", or hema 23a or 28a-1 show any Injury or other traumatic event, it a Medical Event in the most be notified as the state of the control of the co
	/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit

Division of Vital Records, P.O. Box 68760,

Physici /Medic Examin

Funeral

. Decedent's Name (First, Middle, Last)							2. Date of De		V	3. Time of Death
FOSTER McDOWD H	ARRISON						JULY 1	2, 199	8 Yeer	11:56 A
e Facility Name (If not institution, give :	street end number)	PULL			4b. City, Town	or Loc	ation of Deeth	4c. Coun	ty of Deeth	
PRINCE GEORGE'S H	OSPITAL CE	ENTER			CHEVER			PRIN	CE GE	ORGE 'S
. Social Security Number 6. Sex	7. Age ((In yrs. last birt	Months	r 1 Year Days	If Under 24 Hours	Hrs.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	place (Stete or Forei
5/9-54-8582	57	7	Yrs.				NOV. 8			H CAROLIN
Usual Residence of Decedent Oe. Stete 10b. County	1	Oc. City, Town	n or Location							10d. Inside City Limi
			ELLVILL	E						1 ☐ Yes 2 ₩
MARYLAND PRINCE G Oe. Street and Number	EURGE S	MIICH	10f. Zip				T	10g. Citizen o	f What Cou	21
	777									
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3 Widowed 4 Divorced	If Yes, Give Yeer or Dates:		1 🗆 Yes	2 ∑ No	Specify:			Spec	eify: BL	ACK
15. Decedent's Educ	cation	16e.	Decadent's Usua	ial Occup	ation			16b. Kind of	Business/ir	idustry
(Specify only highest grade	completed) College (1-4or 5+)		(Give kind of wo life. DO NOT u	ork done ise retire	during most o d)	workin	9			
12	4		OKKEEPER	3				CITY G	OVERN	MENT
7. Father's Name (First, Middle, Last)			-		18. Mother's	Name	(First, Middle,	Maiden Suma		
JOHN ROBERT HARRIS	ON				ARIO'	гн с	OZART			
9a. Informant's Name/Relationship (Ty		19b.	. Mailing Address	s (Street				er, City or Tow	n, State, Zi	o Code)
PATRICIA BARR-HARR	ISON, WIFE	E 10	304 SEA	PIN	ES DRI	VE.	MITCHE	LLVILL	E, MA	RYLAND 20
De. Method of Disposition		20b. Placa of	Disposition (Nerry, crematory or o	me of			Date	20c. Location		
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State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Decedent's Name (First, Middle, La	ist)	Cer	tificate of	Death	2. Dete of De	Reg. No.	3. T	29 I
Elizabeth Higgin	ns				Month 07	Dey 09	Year	2:10 pm
4a Facility Name (If not institution, given				4b. City, Town, or	1			2.10 Pm
Holy Cross Reha	bilitation &	Nursing	Center	Burtonsy	ille		omery	
5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt	1913	9. Birthplece (5 Country) NEW JEI	State or Foreign
Usual Residence of Decadent 10a. Stete 10b. County	10	c. City, Town or Lo	cation					ide City Limits
MD MONTGOME	ERY	SILVER SP	RING				10	Yes XXNo
MD MONTGOME 10e. Street and Number 3409 B HAMPTON HO	DLLOW		10f. Zip Code 20	904		10g. Citizen of V USA		
11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Ei (Specify only highest gra Elementary/Secondary (0-12)	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Bled Specify	e - American Ind ck, White, etc. WHITE	en,
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17. Fether's Name (First, Middle, Last, JOHN ANDREW KOE					me (First, Middle, E TACAKS		ne)	
19a. Informent's Neme/Relationship (Type, Print)			t and Number or R				
CHARLES NICHOLS-				GE COURT				
20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Specification)	Removel from State	FOREST LA	wn CEMET	ERY	7/15/98		City or Town, St	ete
21. Signature of Funeral Service Licer	Septe	/L De	Name and Address emaine F 20 South	ess of Fecility uneral Ho Washing	ome, Inc	xandria,	, VA.	
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Pert II. Other significant conditions of	contributing to death but no	ot resulting in the un	derlying cause gi	ven in Pert I.	23b. Did 1	obacco use co	ntribute to the c	nuse of death?
					10	Yes 2□ No	3 Probably	4 Unknown
						an autopsy med?	24b. Were aut available completio of deeth?	prior to
					101	res 2000	1 ☐ Yes	2 No
25. Wes case referred to medical examiner?				26. Place of De	eth (Check only o	ne)		
1 ☐ Yes 2 No		2 ER/Outpetient	3LI DOA		Home 5 ☐ Resid	lence 6 Oth	er (Specify)	
27. Manner of Death 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	e con Dines of Ising	At home, ferm, stre		ry at rk? IYes 2 □ No			red per or Rurel Rout	s Number,
29e. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death mination and/or inve	occurred at the tilestigation, in my o	me, date end place opinion, death occi	e, end due to the curred et the time,	cause(s) end me date end plece,	enner es stated. end due to the ca	ause(s)
29b. Signature and title of certifier	10	-	29c. Licens	se number			d (Month, Day, Y	(oar)
30. Neme and eddress of person who	completed cause of death		Print)	#102		8		

Registrar JUL 13 1998

State of Maryland / Department

of Health and Mental Hy	giene (R	2	2	2	0	6
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opc.

Physician	
/Medical	
Examiner	

Funeral

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Director with the Maryland ral', or items 23a or 28a-f show Examiner must be notified at Director permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner manning. Funeral Baltimore, Maryland 21215-0020 þ Completed Be 2 **Physician** /Medicai Examiner Physician/Medical Examiner physiclen end s the burial-transit The lew requires that the death certificate be executed P.O. Box 68760 for use as signed by the e Records, þ Completed is certificate hes b director, page 2 s Division of Vital Hospital or Attanding Physician: 24 hours after death. Be 2 this funeral Certification: After after deat Director: à

Certificate 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month Dav Vaar ELLA REE HAGGINS 1998 JULY 11, 0815PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6102 J. STREET FAIRMONT HEIGHTS PRINCE GEORGES If Under 1 Year 8. Data of Birth JAN 19910 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foreign Months Deys SOUTH CAROLINA 1□ M 20 F 88 Yrs 519-28-0391 Usual Residence of Decedant 10e. State 10b. County 10c. City. Town or Location 10d. Insida City Limits MD Yas 2 No PRINCE GEORGES FAIRMONT HEIGHTS 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6102 J st. UNITED STATES 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ YNo If Yes, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - Amaricen Indian, Black, White, etc. 11. Marital Status Navar Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: Specify: BLACK Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) Collaga (1-4or 5+) BISHOP RELIGION 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumema) WILLIAM BENSON NORA BECTON 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) BARBARA ANTHONY / DAUGHTER 9716 FRANKLIN AVE, SEABROOK, MD 20706 20b. Place of Disposition (Nama of camatary, cramatory or other place)
CEDAR HILL CEMETERY 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 7-17-98 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Fugeral Service Licenses 22. Nama and Addrass of Facility ALEXANDER S. POPE FUNERAL HOME 11081 5538 MARLBORO PIKE FORESTVILLE MD, 20747 23a. Pert . Enter the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cade on each line. Approximate Interval Betwaer Onsat and Daati Immediata Causa (Final disease or condition rasulting in deeth) inhalation mote Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immadiata ceuse. Enter Undarlying Cause (Diseasa or Injury that initietad avants rasulting in daath) Last Dua to (or as a consequance of): Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Limited 1. Yas 2□ No 1 T Yas 2 No 25. Was cesa rafarred to madicel 26. Placa of Death (Chack only ona) Othar: 4□ Nursing Homa 5 the Rasidance 6 □ Othar (Specify) 1X Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Daath Deta of Injury (Month, Dey Yaer) 28b. Tima of 28c. Injury at Work? 28d. Describa how injury occurred 1 Natural 5 Pending -11-98 0800 1 Yas 2. No fire Invastigation 2 Accidant House 6 Could not ba 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide Residence Prince Georges County, Manyland 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, deta and place, and due to the causa(s) and mannar es stetad.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner steted. 29a. Cartifiai (Check only one) 29c. Licansa numbar 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifie

O.C.M.E.

Penn Street, Baltimore, Maryland 21201

JULY 12, 1998

State Registrar

Medical

trphen

31. Data filed (Month, Day, Year)

30. Name and eddress of person who complated causa of daath (Itam 23a) (Type, Print) Radentz,

32. Registrers Signatura

24 hours

To the Hosp within 24 ho To the Fune completely fi

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1998 ea **Physician** NEIL KENNETH **JOHNSON** JULY 13 1315 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Undar 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dala of Birth (Month, Dey, Yeer) **Funeral** 1 → M 2 □ F Days Director FEBRUARY 10,1922 Wash., D.C. 223**–**16–2525 Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 77 is marked other than "natural", or frema 23a or 28a-f show traumatic event, the Mooins! Examiner must be notified at 1 Yes 2 □ No Director MARYLAND PRINCE GEORGE'S SPRINGDALE 10f. Zlp Code 10g Citizen of What Country? 10e Street and Number 3519 EDWARDS STREET 20774 USA Funeral 13. Was Dacedant of Hispanic Origin? (Specify Yes or No. 5. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Americen Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health end Mental Hygiene. important: If item 27 is marked other than "natural", or iter eny injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th LUMBER YARD WORKER PRIVATE 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be NATHANIEL JOHNSON RUTH MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) RUTH COLBERT DAUGHTER 3519 EDWARDS ST. SPRINGDALE, MD 20774 20b. Placa of Disposition (Name of cemetery, cremetery or other place)
LINCOLN CEMETERY 20a. Mathod of Disposition Dete 20c. Locetion - City or Town, Stata 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 7 - 17SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Name and Address of FecilityMARSHALL'S FUNERAL HOME OF MD LACCE COLC4308 SUITLAND ROAD SUITLAND, MD 23a. Part1. Enter the diseasa, or emplications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition rasulting In daath) /Medical gastroenteritis Examiner Examiner rointestina attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated events resulting in death) Last Records, P.O. Box 68760 Generalized Physician/Medicai Due to (or es a consequence of) Part II. Other algoriticent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of deeth? ed by the 1 Yes 2 No 3 Probably 4 Unknown Myo Candial signed l þ 24b. Were eutopsy findings available prior to Completed 24e. Wes en eutopsy Fail completion of cause of daath? hes Primary 1 Yes 2 No 1 Yes 2□ No certificate Division of Vital or Attending Physician: 25. Was casa rafarred to madical examiner? director Be 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1 Yas 2 No Certification: To 1 Inpaliant 2 ER/Outpaliant 3 DOA this After this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Director: Af 1 Yes 2 No investigation 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

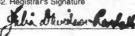
Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) To the P within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and itle of certifier 29c. License number

State Registrar 31. Date filad (Month, Day, Year)

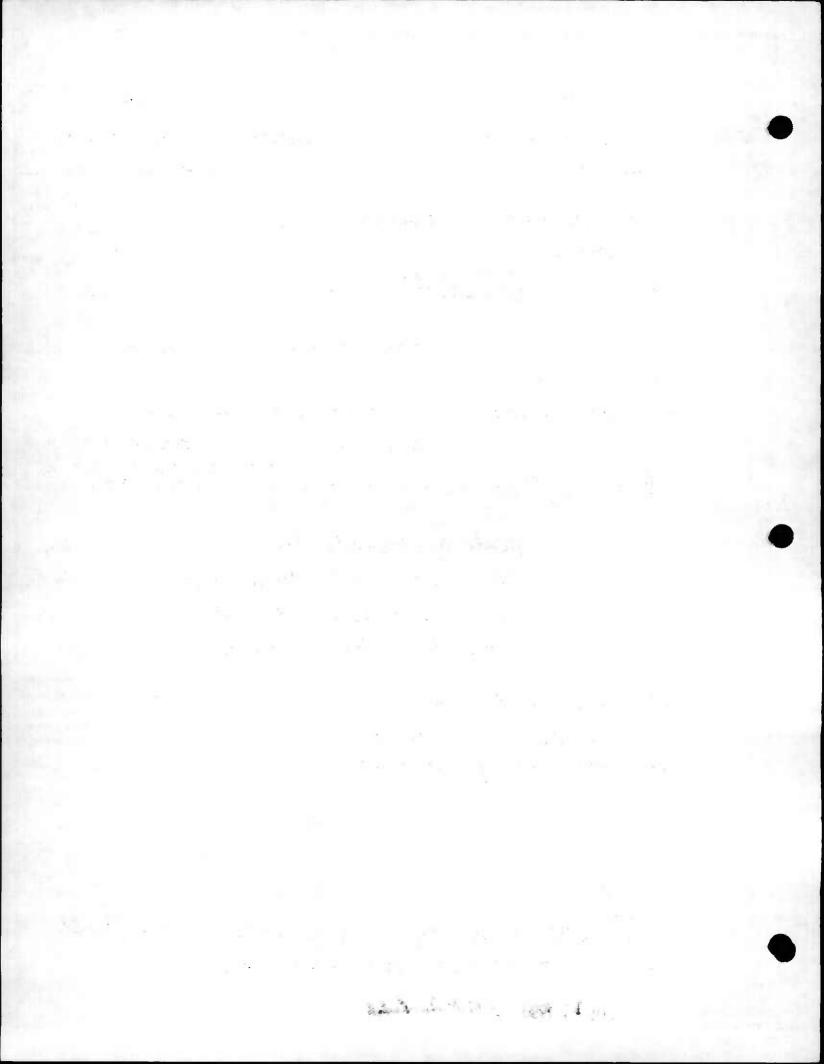
30. Nama and address of person who carried RAKISH ARORA, MD

32. Registrar's Signature

completed ceuse of death (Item 23a) (Type, Print)
3001 HOSPITAL DRIVE



CHEVERLY, MARYLAND



98-3882-033

JAMES JOHNSON State of Maryland / Department of Health and Mental Hygiene | Q | Q

Physician
/Medical
Examiner

James Phillip

3. Time of Deeth 1:15P.M.

Ohio

10d. Inside City Limits

1 Yes 2 □ No

PRINCE GEORGES

Funeral Director

Director Funeral þ

Completed Be

death with the Meryland r than "naturel", or items 23s or 28s-f show the Medical Experies must be notified at filed within 72 hours efter 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Nem 27 is marked othe eny linjury or other traumatic event Biole.

Physician /Medical Examiner

Examiner The law requires that the death certificate be executed ettending physician end for use es the buriel-tran Division of Vital Records, P.O. Box 68760, Physician/Medical ò Completed is certificate has director, page 2 Hospital or Attending Physician: Be 10 this To the Hospital or Attending Phy within 24 hours effer deeth.

To the Funeral Director: After this completely filled in by the funeral is Certification: edical

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 07,1998 Johnson 4c. County of Deeth 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, give street end number) BELTSVILLE 4909 HARFORD AVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 1 M 2□ F Months 40 216-74-4148 Sept 24, 1957 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Maryland Prince George's Beltsville 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 4909 Harford Avenue 20805 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien 11. Marital Status Bleck, White, etc. 1 XYes 2 No 1976
If Yes, Give
Yeer or Dates: 1977 1 XNever Married __ 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Patient Transport Specialist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Peter Johnson Hazel Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Peter Johnson/Father 9242 Sealed Message Road, Columbia, Maryland 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Quantico National Cem. 7/13/98 4 ☐ Donetion 5 ☐ Other (Specify) Triangle, Virginia 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest,

Approximate Approximate Shock, or heart failure. List only one cause on each line. etgin Wourd fmmediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of deeth? 2X No 3 Probably 4 Unknown 1 Yes

24a. Was an autopsy performed?

Yes

24b. Were autopsy findings available prior to completion of cause of deeth?

2 No

Yyes

25. Was case referred to medical examiner? 1 XYes 2 □ No

27. Menner of Death

1 Netural

2 Accident

30 Sulcide

Hospital: 28a. Date of Injury (Month, Dey Yeer) 5 Pending investigation

1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. fnjury et Work? 1 Yes

Other: 4 Nursing Home 5 🕅 Residence 6 □Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hon

198

1909 Harbord Av

2 No

1 Certifying Physicfen: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and manner stated. 29a. Certifier (Check and

29b. Signature d title of certifier 29c. License number

O.C.M.E.

29d. Dete signed (Month, Dey, Yeer)

Name son who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

JULY 8,1998

MD 32. Registrar's Signeture

6 Could not be determined

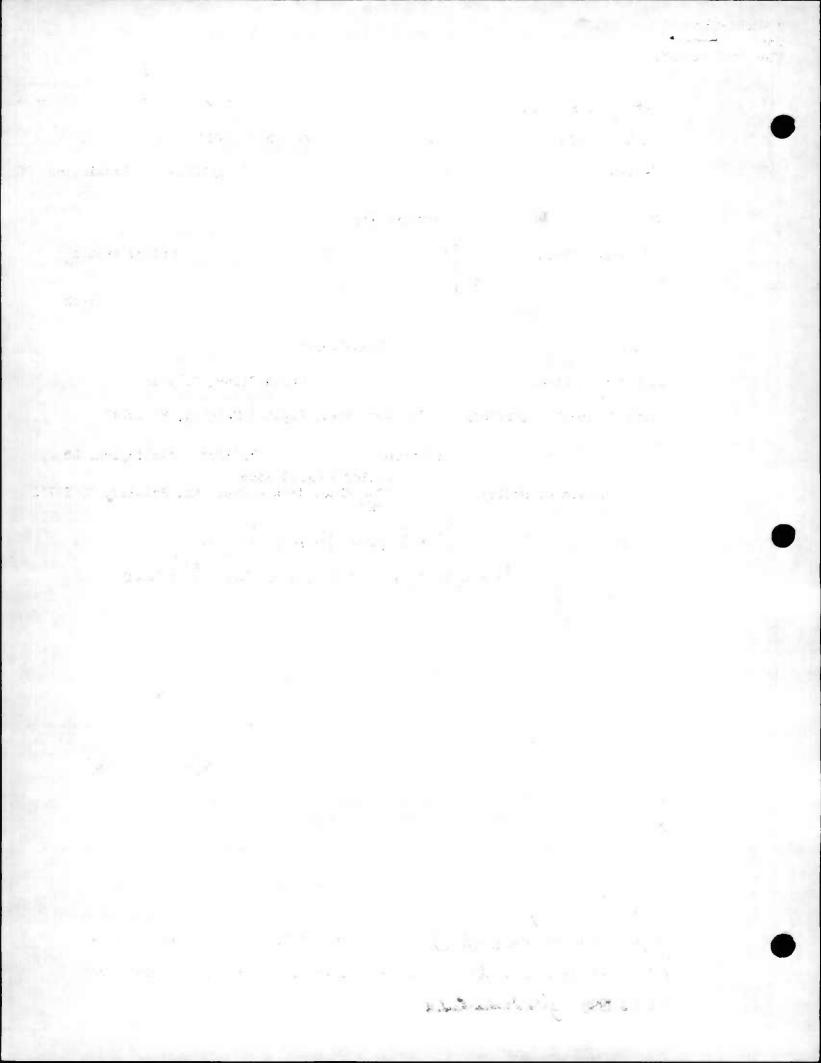
State Registrar

Assistant Park Aller of Artist and the A SOURCE OF THE RESIDENCE En and the State of the the series of the weeking.

			State of Ma	-	epartment of I Certificate of			giene 9 Reg. No.	8 23295
Physici /Medic		Decedent's Name (First, Middle, La MASON	MADDOX		JOHNSON		2. Dete of De Month	Day	3. Time of Deeth
Examir		4a. Fecility Name (If not institution, given DOCTOR S HOSPI)				4b. City, Town, or LANHAM		PG	
Funeral Director			Sex 7. Age	83	hday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De	y Yeer)	9. Birthpiace (State or Foreig
ms 23a or 28a-f show	ctor	10a. State 10b. County MD PG		10c. City, Town	or Location				10d. Inside City Limit
Nerve 23a or 28a-1 sho	al Director	9621 ARDWICK ARDI	MORE ROAD		10f. Zip Code 20774	4		10g. Citizen of V	
natural, or items dical Examinar m	by Funeral	11. Maritel Status****SINGLE: 1 Never Married 2 Married 3 Widowed 4 Divorced	12 Wes Decedent B ** Armed Forces? 1 AYes 2 1 If Yes, Give Vear or Dates:	S ARMY)	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No o Rican, etc.)	14. Race Blec Specify	e - American Indien, k, White, etc. BLACK
iene. ' than "natur the Medical.	Completed	15. Decedent's E. (Specify only highest green street only highest green street on the street of the street on the	ducation ede completed) College (1-4or 5-	+)	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire (RUCK DRIV	during most of word)	king	16b. Kind of Bu	siness/Industry ERNMENTAL)
Mental Hyg srked other atic event,	To Be C	17. Fether's Neme (First, Middle, Last, WELLINGTON JOHNS						, Maiden Sumam NN RAGSD	,
neri of Health and int: if litem 27 is ma iry or other traum	10		COUSIN) Removel from State	20b. Place of	Mailing Address (Street 621 ARDWIC) Disposition (Name of 1200)	ARDMORE	RD., S	PRINGDAL	E, MD., 2077
Departmen Important: any injury 9059-		4 Donetion 5 Other (Specification of Funeral Service Licer			22. Name end Addre	ess of Fecility J		RHINES C	O., INC. DC 20017
physician end Medicai xaminer fue privile priv	dical Examiner	23a. Pari. Enter the disease, or complete, or heert feilure. List only Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underfying Cause (Disease or injury that Initiated events	e	Due to (or es e co	Onsequence of):				Intervel Between Onset and Deeth
ed by the attending phy detached for use as the	Physician/Medi	Pert II. Other significant conditions of	dontributing to death bu		the underlying cause given				tribute to the cause of dea
s been sign should be	Completed by P	Diabetes mell hypertensio	N			8	24a. Wes	en eutopsy ormed?	24b. Were eutopsy finding evalleble prior to completion of ceuse of deeth?
pag	Be Con	CHORIC Obst	ruchte pul	lmonon	Diserie	26. Plece of Dec		Yes 2 00	1 ☐ Yes 2 ☐ No
ter this neral di	Certification: To B	exeminer? 1	28e. Dete of Injun (Month, Dey	y 28b. Ti	me of jury 28c. Injury Wo	ner: 4□ Nursing H	lome 5 Resi	dence 6 □Othe	
within 24 hours after death. To the Funeral Diractor: All completely filled in by the fu		3 Suicide 4 Homlcide 6 Could not be determined	building, etc.	."(Specify)	m, street, factory, office		City or To	wn, Stete)	er or Rurel Route Number,
in 24 h he Fun pletely	edical	(Check only one)	niner: On the best of end menner stat	exemination end	death occurred et the til for investigation, in my c	me, dete end piece ppinion, death occu	red et the time,	date end place, e	nner es steted. and due to the ceuse(s)
the own	W	29b. Signeture end title of certifier	5 Jan	· Jus	29c. Licens	(17)		7/7	(Month, Dey, Yeer)
101		30. Name end eddress of person who	completed cause of de	eath (Item 23e) (1	ype, Print)	Rlad	Lanhan	my z	2706

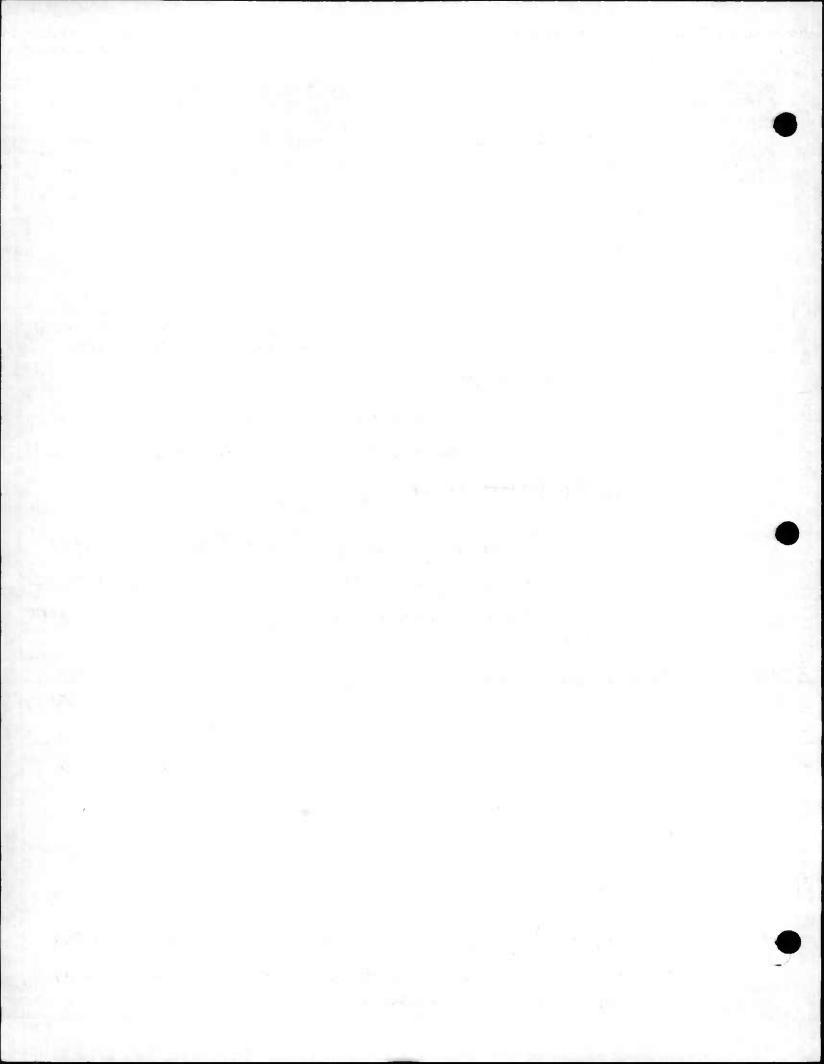
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			8-13-98 WR.	Cel	lillicate	e or L	Death			Reg. N	No.		
Physic	cian	Decedent's Name (First, Middle, L.	ast)						2. Dete of D Month		Ову	Yeer	3. Time of Deeth
/Med Exam	lical	Ethel Marie 4 4e Fecility Neme (If not institution, gr				4	b. City, Tov	wn, or Lo	JULY cation of De		1998 4c. County		1530PM
Exam	mici	1813 TANOW PLAC	Œ				CAPIT	OL H	EIGHTS	3	PRINC	E GEO	RGES
Funera	il			rs. lest birthdey)	if Under Months		If Under 2 Hours		8. Date of E (Month,				aca (Stete or Foreign
Directo	r	214-60-3309 Usuel Residence of Decedent	I M ZAJF	14 Yrs.					01/1				ington, DC
show a st	_	10e. Stete 10b. County		City, Town or Lo	ocation							10	d. Inside City Limits
Be-f	Director		Georges	Foresty						T			1X Yes 2 No
with the	Ö	10e. Street end Number			10f. Zip					10g. 0	Citizen of V	Whet Countr	ry?
72 hours after death with the Maryland natural, or items 23a or 28a-f show acal Examiner must be notified at	Funerai	1813 Tanow Place	12. Was Decedent Ever In	U.S. 13.	Was Deced	2074 lent of HI		gin? (Spe	cify Yas or I	No-	Jnited 14. Race	d Stat	tes in Indien,
r Ren	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 🔯 No		Was Deced			, Puerto I	Rican, etc.)			k, White, e	
ours a	by	3 ☐ Widowed 4 ☐ Divorced	It Yes, Give Yeer or Detes:		1 ☐ Yes 2	2XI No	Specify:				Specify		lack
72 hours 'natural', dical Ext	Completed	15. Decedent's E (Specify only highest g	Education trade completed)	16e. Dece	dent's Usua kind of word DO NOT us	l Occupa	ation during most	of worki	ng	16b.	Kind of Bu	usiness/Indu	ustry
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filed v Hygle ther t		12th 17. Fethar's Neme (First, Middla, Las	st)		House	кеер	~	r's Nama	(First, Midd				
S E S	To Be	Robert L. John:							trong-				
2 should and Men is merke	ř	19e. Informent's Name/Relationship		19b. Maili	ing Address	(Street						State, Zip (Code)
1 and 2 Health a am 27 is		Sarah M. Heath	(Mother)	717 N	Nova A	ve.	Capi	itol	Heigh	ts.	MD 20	0743	
of Ham		20a. Method of Disposition	208	. Place of Dispo	osition (Nam	ne of			Date	-		City or Tow	vn, Stete
age age		1 N Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Spec		Clenwoo		emet		7	/11/98	v	Nachi	ngton	DC
Department Popular any Injura	ġ	21. Signature of Fuperal Sarvica	erroge /	// 22	2. Nama and	d Addres	s of Facility	У			IGSIIII	ugcun	, DO
Dep den den de de de de de de de de de de de de de	3	- Commercial Edward	M. Dudley	Table 1	Oudley					144	Dain	ier N	MD 20712
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Physiciar /Medica	3		y one ceuse on each line.	not ent	ter the mode	e of dyin	g, such as	cardiac o	Ave., or respiretory	MT.	NaIII.		Approximete Intervel Between
Examine	t 💮	immediate Ceuse (Finel disease or condition	y one cause on each line.	b At	ter the mode	e of dyin	g, such as	cardiac o	Ave., or respiretory	errest,	Rain.		
Examine	t r	immediate Ceuse (Finel	e	o (or es a consec	ter the mode	e of dying	g, such as	cardiac o	Ave., or respiretory	errest,	Rain		Approximete Intervel Between
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State of Maryland / Department of Health and Mental Hygiene 0.0

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/Medi		4a. Facility Neme (If not Institution, gi		ies		4b. City, Town, or Lo	July	1	998	0147
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		Harford Memori 5. Social Security Number 6.	Sex 7. Age (In yrs.	last hirthd	lf Under 1 Yaa	Havre de				ford
Funeral Director	I		1□M 2\\ F 91	Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Dey April 2	5,1907	Cou	place (Stata or Foreign ntry) 1 ryland
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death with the Maryland ms 23a or 28a-f show	Director		ecil			rryville				1 ☐ Yes 2 🎇 No
h with t		10e. Street and Number 80 Patterson Aven	ue, P.O. Box 5	03	10f. Zip Code	21903	1	0g. Citizen of U	Whet Cou	-
deat	Funeral	11. Marital Stalus	12. Was Decedant Ever in U Armed Forces?	J,S. 1	3. Was Decedent of	Hispanic Orlgin? (Spe ban, Mexican, Puerto	cify Yes or No-			can Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if items 23e or 28e-f show important: if item 27is marked other than "natural", or items 23e or 28e-f show all plury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XX\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		1 ☐ Yes 2 XXNo		Hican, etc.)	Specif	ck, White,	eic. Thite
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Registr	ar	JUL 15 1	32. Registrer's Signatura	dout	A PARTY					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey **Physician** 1998 8:10 pm Leon F. Kern July. 12, /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's 6802 Elbrook Road Lanham If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Funeral Days Months 1X M 2□ F 80 Vre 226-09-9984 Director March 28, 1918 Pennsylvania Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 6802 Elbrook Road 20706 U.S.A. death Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 ☐ Yas 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) 11 Baker Proprietor permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe eny Injury or other traumatic event, bince. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ellwoo Leon Kern 2 Nellie Watts 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Nellie A. Jones - Daughter 16030 A English Oaks Avenue, Bowie, Maryland 20716 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mount Hebron Cemetery 7/16/98 Winchester, Virginia 21. Signature of Funeral Service Licensea 22. Nama and Addrass of Fecility Gasch's Funeral Home asch 4739 Baltimore Avenue, Hyattsville, MD 20781 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** tole cancer, terminal Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Examiner requiras that the death certificate be axecuted bunial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of): ed by the attending physician detached for use as the buna P.O. Box 68760. Physician/Medical Due to (or as e consequenca of) Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by by should be 24b. Wera eutopsy findings evellable prior to completion of cause of deeth? Completed 24a. Was en autopsy performed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred : Aftar ! 5 Pending Investigation il or Attending s after death. il Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by 4 Homicide To the Hospital or ithin 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated. edical complataly 2 Medical Examinar: On the bests of examinetion end/or Investigation, In my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one)

State Registrar 29b. Signature end title of cartifier

31. Date filed (Month, Day, Year)

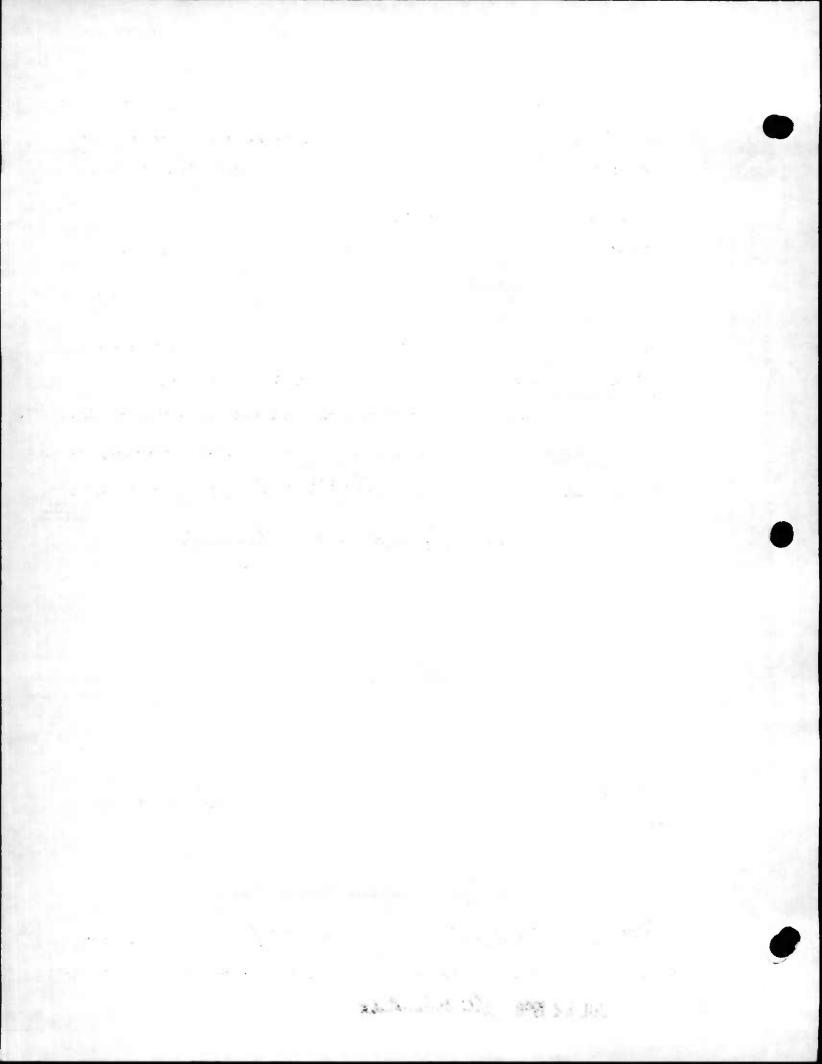
Tsunie Chanchien, MD,

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)



8824 Cunningham Drive, Suite A, Berwyn Heights, MD

29d. Data signed (Month, Dey, Year) July 13, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month July 1, 1998 4:11p.m. Dae Sop Lee 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 8. Date of Birth (Month, Dey, Year) July 22, If Undar 1 Yaar | If Undar 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number (In yrs. lest birthday) Months Days 10 M 20 F Hours Korea 223-71-5297 52 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits MYes 2□No Silver Springs Md. Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20904 14 Castle Cliff Ct. Korea 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Yeer or Dates: Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Cleaners 12 17. Fether's Name (First, Middle, Last) 18. Mother's Nema (First, Middla, Malden Sumema) Sang IN Lee Jung Jong Lee 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20904 14 Castle Cliff Ct., Silver Springs, Md. Sang In Lee 20b. Pleca of Disposition (Neme of cemetery, cremetery or other plece 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ➡ Burlel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Gates of Heaven Cem. 7-7-98 Silver Spring, Md. 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Funeral Services Assoc. 1425 Mary. Ave. N.E., Wash, D.C. Approximate Intervel Between Onset end Death 23e. Pert1. Enter the dispesse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Immediete Ceuse (Finel diseese or condition resulting in deeth) (YMPHOMA 2 Mon MIS Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en autopsy 1 ☐ Yes 2 No 1 ☐ Yes → No 25. Wes case raferrad to medical 26. Piece of Deeth (Check only one) Hospitai: planatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Examiner Examiner law requires that the death certificate be executed and burial-trar physician s the burial Physician/Medical

Physician

Examiner

Funeral

Director

arked other than "natural", or items 23a or 28a-f ahov estic avent, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter

al Hygiene.

is marked of

permit. Pages 1 and 2 s Department of Health en Important: If them 27 ia i any injury or other trau

Physician

/Medical

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signed by t

peeu

certificate

or Attending Physician: after deeth. Director: After this certifice

24 hours Hospital

To the Vithin 2

Division of Vital

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Completed

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Certification:

Medical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest

1 Yes 2 No 27. Magner of Deeth 1 Naturel 5 Pending 2 Accident investigation

28e. Date of Injury (Month, Dey Year)

ayoul M.D.

28b. Time of 28c. Injury et Work? Injury 1 Yas 2 No

28d. Describe how injury occurred

3 Suicide 6 Could not ba Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signeture and title of cartifier

31. Dete filed (Month, Day, Year)

29c. Licensa number MD 42452 29d. Data signed (Month, Day, Year)

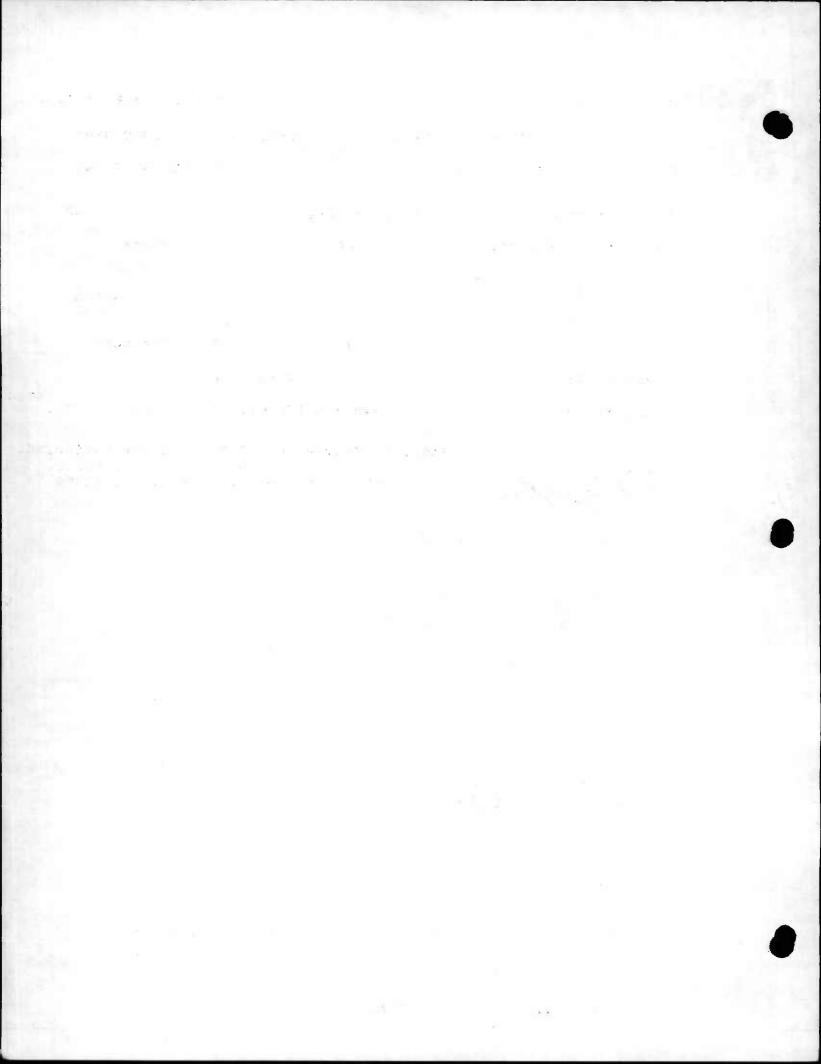
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111, PRINCE PHILIP DRIVE, # 327

DR. CHIRA RATA GOPAL, M.D. OLNEY mD 20832

State Registrar



DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle, Las	t)		tificate of		2. Dete of Dee		3. Time of Deeth
ysician Medical	MILTON H. LACH	OWSKI				Month	Day	498 1030 Am
caminer	4a. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or Lo		4c. County	of Deeth
	FALLSTON GENERAL			W.I	FALLSTON			RD COUNTY
neral ector	5. Social Security Number 6. Security Number 219-01-5375	7. Age (<i>In yr</i> s	s. last birthdey) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Dete of Birt (Month, De) FEB . 7,	7, Yeer) 1919	9. Birthplace (State or Foreign Country) MARYLAND
IN IN	10a. State 10b. County MARYLAND HARFORD		City, Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2X No
Director	10e. Street end Number	COUNTY B	EL AIR	10f. Zip Code			10g. Citizen of V	
1 0		VENUE		2101	4			STATES
any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in I Armed Forces? 1 1 Yes 2 □ No If Yes, Give Yeer or Dates:			Hispenic Origin? (Speen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
ted les	15. Decadent's Edi	ucation	16e. Deced	ent's Usual Occup	petion		16b. Kind of Bu	usiness/Industry
n, the Medical	(Specify only highest gred Elementary/Secondary (0-12) 12	College (1-4or 5+)			during most of worki d) SENTATIVE			G MACHINE
o Co	17. Fether's Neme (First, Middle, Last)		SERVI	CE KEPKE	18. Mother's Name		MANUFAC Maiden Sumem	
To Be	At the many to the many				CATHERIN			
T	19a. Informent's Name/Reletionship (T	ype, Print)	19b. Mailin	g Address (Street	end Number or Rure			Stete, Zip Code)
or tra	RUTH N. LACHOWSKI	, WIFE	719 R	OCK SPRI	NG AVENUE	, BEL A	IR, MAR	YLAND 21014
5	20e. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ f	20b.	Plece of Dispos			Date	-r	City or Town, Stete
2	4 □ Donation 5 □ Other (Specify)			OLN CREM		/11/98	BRENTWO	OD, MARYLAND
clan	23a. Pert1: Enter the disease, or comp shock, or heert feilure. List only o	lichtons that caused the dec	W 34	01 BLADE	LN FUNERA CNSBURG RD ng, such es cardiac c	. BREN	TWOOD,	MARYLAND 20722 Approximete Intervel Between Onset end Deeth
lical iner	Immediate Ceuse (Final disease or condition resulting in deeth)		MOWI		* ***			1 WEEK
ě			(or es e consequ		100			15000
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use as the bunal-transit	Cause (Disease or Injury that initiated events resulting in deeth) Lest	cDue to (or es e consequ	uence of):		7.75		
Sicis	Pert If. Other significant conditions co	ntributing to death but not re	sulting In the un	derlying cause giv	ven in Pert I.	23b. Dfd t	obacco uee coi	ntribute to the cause of death?
be datached for use by Physician/N	CARDIOMYOPA						res 250No	3 ☐ Probably 4 ☐ Unknown
should		/				24e, Wes	en eutopsy med?	24b. Were eutopsy findings evelleble prior to completion of cause of deeth?
Con						101	es 2000	1 ☐ Yes 2月0No
Be	25. Wes case referred to medical exeminer?	Lla amita li			26. Plece of Deeth	(Check only o	ne)	
- To	1 ☐ Yes 2 No 27. Menner of Deeth		ER/Outpetient	3LI DOM	her: 4 Nursing Ho			
led in by the funera Certification:	1 Neturel 5 Pending investigation 3 Suicide 6 Could not be	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury		Yes 2 □ No		ow injury occur	
led in by the fune Certification	4 Homicide determined	28e. Pleca of Injury - At I building, etc. (Spec	nome, farm, stre	eet, factory, offica		28f. Location (S City or Tow		er or Rural Route Number,
sompletely filled in by the funerel Medical Certification: 1	29a. Certifier 1 Certifying Phy (Check only 2 Nedical Exami	elclan: To the best of my kn iner: On the basis of examin end menner stated.	owledge, death etion end/or inv	occurred et the tir estigation, in my o	me, dete end place, oppinion, deeth occurr	end due to the ded et the time,	euse(s) end me date end place,	enner es steted. end due to the cause(s)
M	29b. Signeture and title of certifier			29c. Licens				d (Month, Dey, Year)
1	DIC. IIIV			D	22843		JURY 1	1998
4	30. Neme end eddress of person who co	ompleted cause of deeth (Ite	m 23a) (Type F	Ininti				
)	12. PHICUPS		SPMME	rus	22843 FOMUT 1HU	(m)	20	070

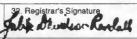
	23	PART I, 27, 28B, F PER 1. Decedant's Name (First, Middla,		30 1111	Ocitino	ale of	Death	2. Date of De	Reg. No.	8 2330
Physic	ian	Le Roy Lagana	Lasty					Month	Day	Yaar
/Med Exami		4a Facility Name (If not institution,	give street and number)				4b. City, Town, or		22, 1998 h 4c. County	of Death
LAGIIII	iici	6514 MARLBORO P	IKE-WOODED	AREA			DISTRICT	HEIGHTS	PRINCI	E GEORGES
Funeral Director		5. Social Security Number 6 Unknown Usual Residence of Dacedant	Sex 7. Age 1 M 2 □ F	e (In yrs. last bii 48	Yrs. If U	Inder 1 Yea ths Day			th ay, Year) 3, 1950	9. Birthplace (State or F. Country) Maryland
show	'n	10a. Stata 10b. County	0	10c. City, Tow						10d. Inside City L
28e-	Directo	Maryland Prince 10e. Street and Number	George's	Ber	wyn He	Ignts f. Zip Code			10g. Citizen of V	What Country?
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BILLIN	Funeral	11. Maritai Status	12. Was Dacedant I	Ever in U,S.	13. Was D	ecedant of specify Cu	Hispanic Origin? (Suban, Mexicen, Puer	Specify Yas or Norto Ricen, etc.)	o- 14. Raci Biad	e - Americen Indian, ck, White, etc.
natural, or items 23a or 28a-f show	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10			o Specify:		Specify	
	Completed	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5		Decedant's (Giva kind o lifa. DO NO	Usual Occ of work don OT use reti	upation le during most of wo red)	orking	16b. Kind of Bu	usiness/Industry
or the	Com	10	- Condge (1 total		ainten	ance	Worker		Plumbi	
marked other than "	Be	17. Father's Name (First, Middle, La							, Maiden Sumam	
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nent of I	0	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ry, cramatory Nation:			7/27/98	Laurel.	Maryland
Depertmen Important: any Injury ance.		21. Signatura of Funaral Sarvice Lic		,	22. Nam	na and Add	lress of Facility		Daurery	, mary rand
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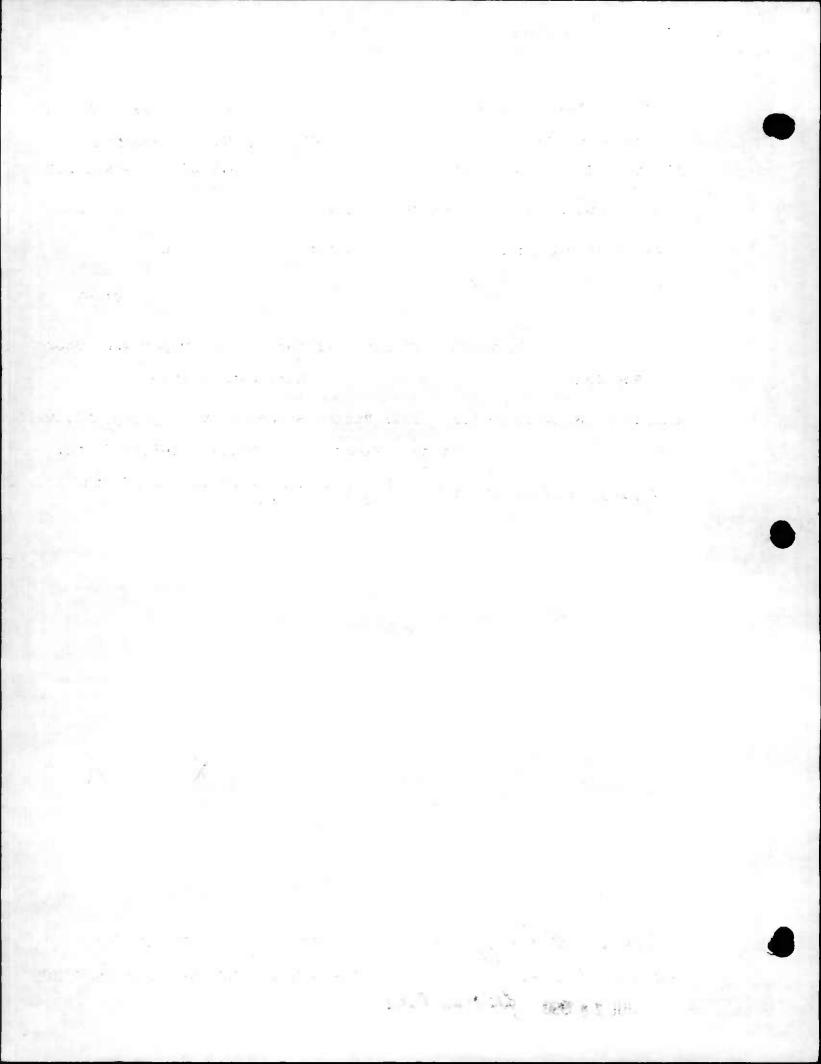
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State Registrar THEODORE M. King 31. Data filad (Month, Day, Year)



111 Penn Street, Baltimore, Maryland 21201

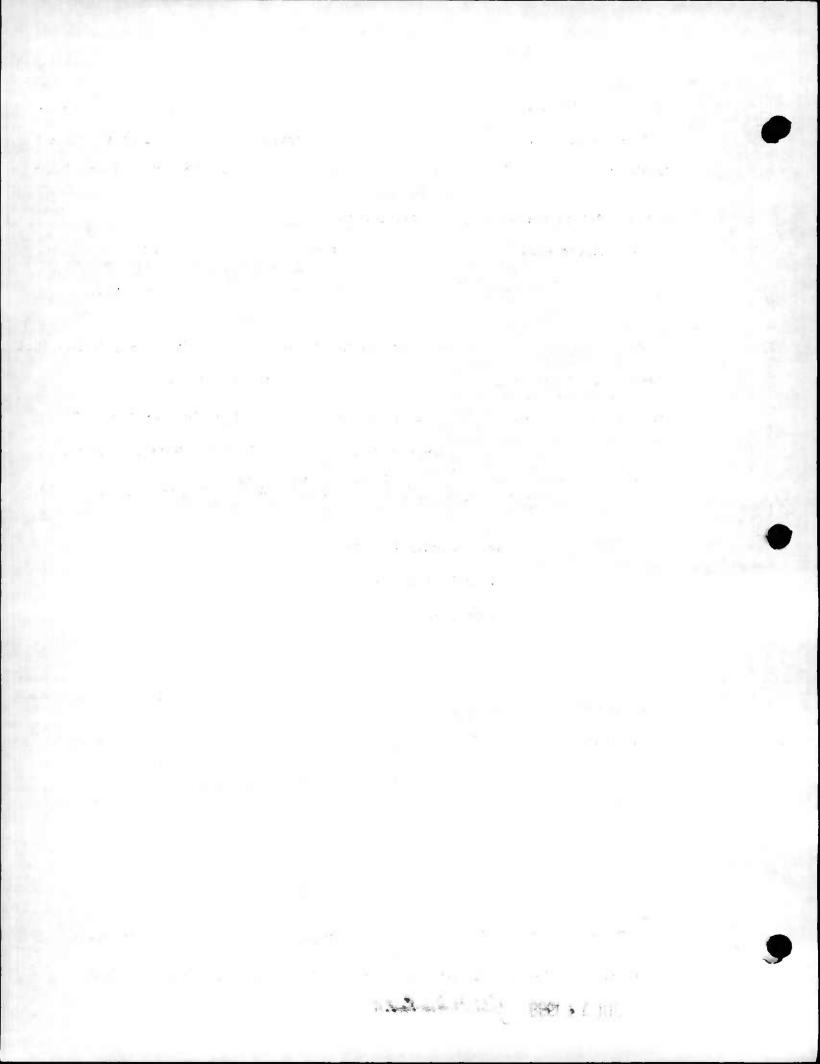


State of Maryland / Department of Health and Mental Hygiene 23303 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yes **Physician** 12, Marie F. Marshall July 1998 5:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's 4101 Clagett Road Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2\ F Yrs. 84 Pennsylvania Director July 25, 1913 577-07-3767 Usual Residence of Decedent with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits show permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryle Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28s-4 show any Injury or other traumatic event, in Medical Examiner must be notified a page. 1 Yes 2 No Directo Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4101 Clagett Road 20782 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Detes: 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Occupational Therapist 10 St. Elizabeth Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward B. Ferguson Marie A. 0'Day 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Ball - Daughter 4101 Clagett Road, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 7/15/98 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral)Service Licensee 22. Name end Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781 Consta laser nee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONARY ARREST Examiner Due to (or as a consequence of) Examiner SEVERE DEHYDRATION ettending physician end for use es the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760, MALNUTRITION Physician/Medical Due to (or as a consequence of) the Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by the 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown COLON CANCER þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed AZOTEMIA pege 2 1 Yes 2X No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice. 25. Was cese referred to medical examiner?
1 ☐ Yes 2 ☒ No funeral director, Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident To the Hospital or Atternin 24 hours after der the Funeral Director completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ildul mg D39501 July 13, 1998 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Hugh M. Holder, MD., 13605 Baden Westwood Road, Brandywine, Maryland 31. Date filed (Month, Day, Year) 32. Registrer's Signature Adi Studion Rankell

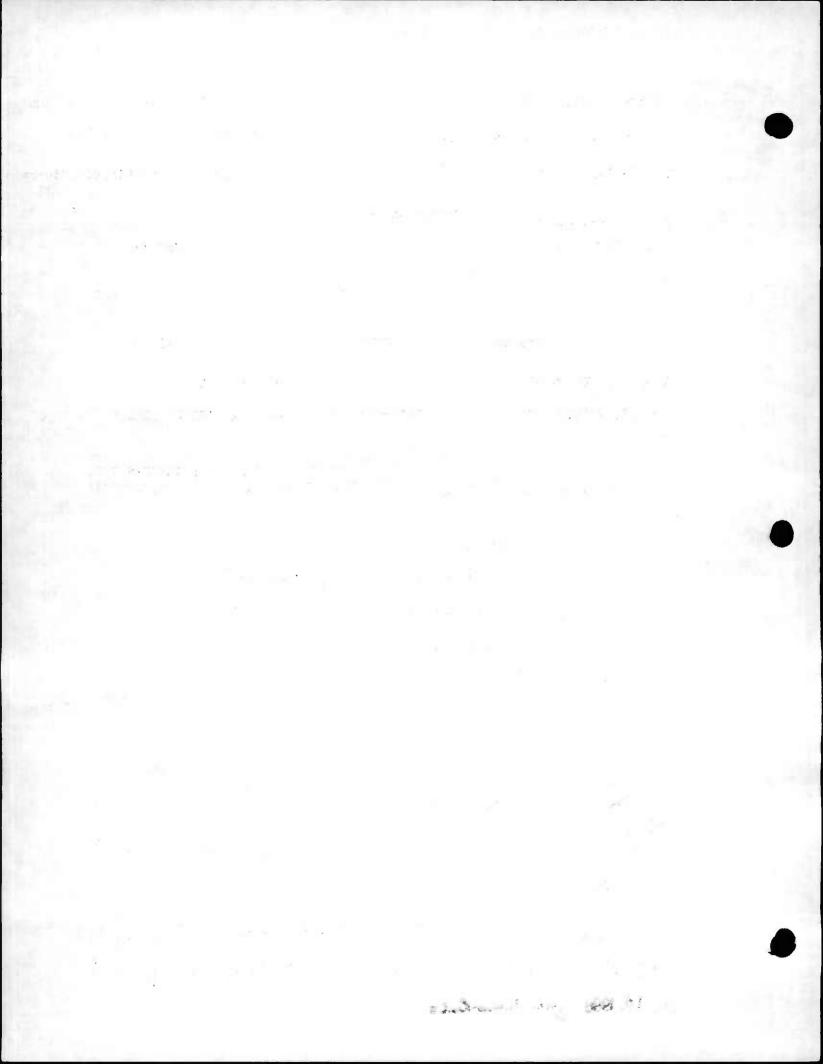
DHMH 16 Rav 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

and Mental Pyggene. In marked other than "returnal", or items 23s or 28s-f show unmarked other than "returnal", or items 23s or 28s-f show unmarked overt, the Medical Examiner must be notified at 100 and 1	Jsual Rasidance of Decedent Joa. Stete Job. County Md. Montgome Joe. Street end Number 2 WALKER ROAD Joe. Street end Number 2 WALKER ROAD Joe. Street end Number 2 WALKER ROAD Joe. Street end Number 2 WALKER ROAD Joe. Street end Number 2 WALKER ROAD Joe. Street end Number 3 Widowed 4 Divorced Joe. Decedent's E (Specify only highest grave) Joe. Fether's Neme (First, Middle, Last AARON B. MILTON Joe. Informent's Name/Reletionship (MARK MILTON/BROTH Joe. Method of Disposition J. Buriel 2 Cremetion 3 C 4 Donation 5 Other (Special	ADVENTIST Sex ADVENTIST Fox 12. Was Decedent E Armed Forces 1 Yes E Yes Wer or Detes: ducation ade completed) 3 years Type, Print)	(In yrs. last birth 10c. City, Town Gaither Ever In U.S.	or Location Sburg 13. Was Decellif Yes, sp. 1 Yes	Deys Code Code Code Code Code Code Code Code Code No	Ab. City, Town, or Lo ROCKV. If Under 24 Hrs. Hours Min. 0874 Hispenic Origin? (Spen, Mexican, Puerto Specify:	cation of Deett ILLE 8. Date of Bir (Month, Da Sept.,	MOI th, Year) 5, 1963 10g. Citizen of LIBERIA 14. Re Bla Specia	y of Deeth NTGOME 9. Birthplece Country) Liberi 10d. Whet Country? A ca - American lack, White, etc.	e (State or Foreign a , Monrov Insida City Limits 1 X Yes 2 □ No			
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(2)	Wilhuman	~ 7. 1	vinale		DI	15285		July 1	3, 19	18			
9/3	30. Name end addrags of person who	10111	eath (Item 23e) (Type Print)	h.,	Suite 21	2,01	lney	Md				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death **Physician** HAROLD L. MANGRUM JULY 13, 1998 9:53PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth MAY 6, 1928 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Deys 1€ M 2□ F WASHINGTON, D.C. 70 Yre Director 578-36-5582 Usuel Residence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Expurite must be notified at once. 10b. County 1€ Yes 2 No Directo DC WASHINGTON, D.C. 10g, Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Funeral 1724 INDEPENDENCE AVE. S.E. 20003 UNITED STATES AMERICA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK by 3,□ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) MAINTENANCE PRIVATE 12th GRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ပ EDWARD MANGRUM VIRGINIA GRAVES 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 255 58th ST. N.E.#32, W.D.C. MARGARET O. CARTER 20019 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ▼ Bunial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) JULY 22, 1998 GLENWOOD CEMETERY WASHINGTON, D.C. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility JOHNSON & JENKINS, INC. 716 KENNEDY ST. N.W., W.D.C. 20011 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. Uno Approximete Intervel Between Onset end Deeth **Physician** Cardine arythricis Immediate Ceuse (Final disease or condition resulting in deeth) Jv e alitui Nui Examiner Due to (or es e consequence of): END STAJ New L Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in death) Lest Due to (or es e consequence of): the death cartificate be axed May Yer P.O. Box 68760. Physician/Medical Due to (or es e consequence of): usa as signed by the a Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed paga 2 s 1 Yes 2 No 1 Tyes 2 No cartificata Division of Vital Hospital or Attending Physician: diractor Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No funaral Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Natural 2 🗆 No 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) In by 4 \ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. edicai 29a. Certifler (Check only one) To the To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier 30. Nemse end eddress of person was completed cause of death (Item 23e) (Type, Print) 1328 Southern Avel 4202

WAShington

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

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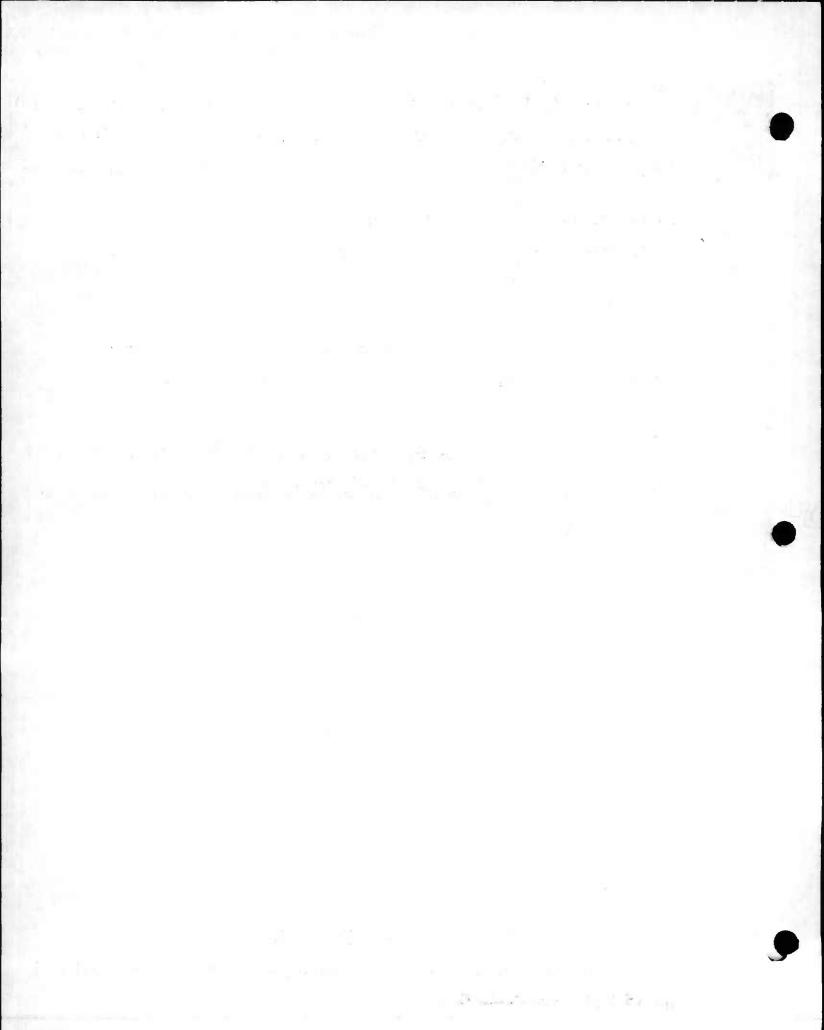
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State of Maryland / Department of Health and Mental Hygiene

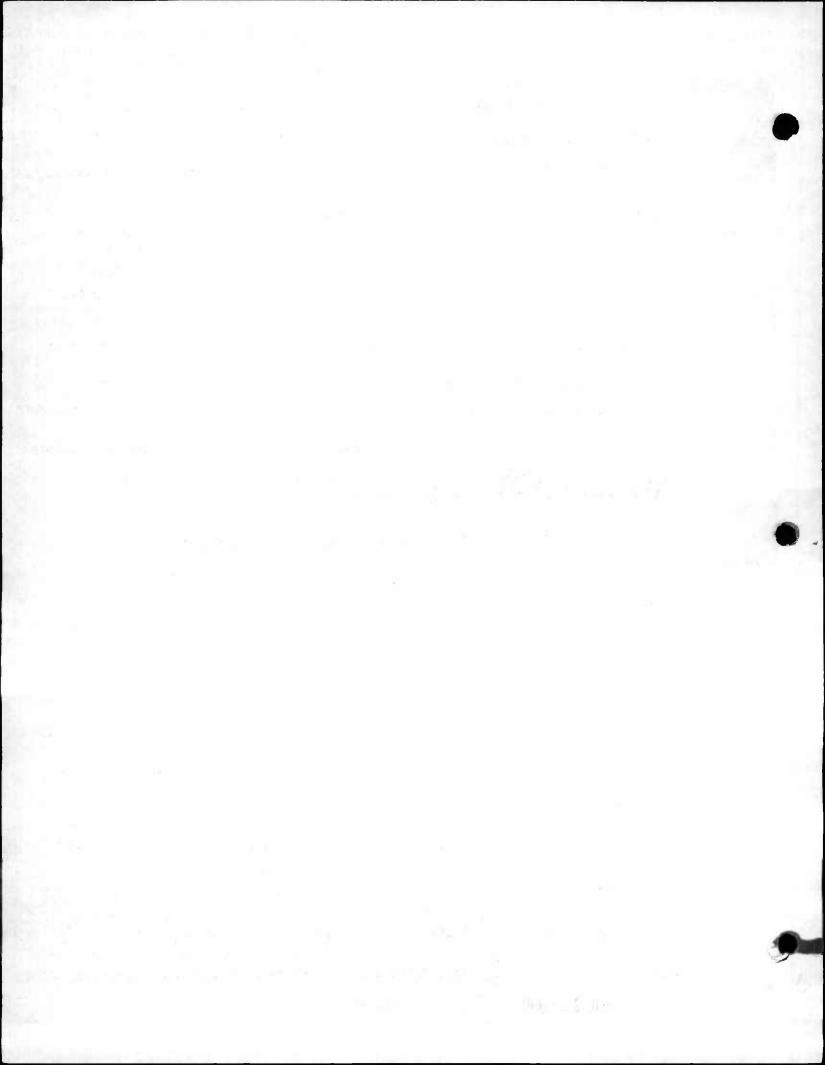
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physiclan** Hazel Blackburn McLay 8:00 a.m July 1 17 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1493-95 Clayton Street Perryville Ceci1 8. Dete of Birth (Month, Dey, Year)
Dec. 12, 1 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 213-48-7941 Yrs 94 Director 1903 Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Port Deposit 1 ☐ Yes 2XINo Director Maryland Ceci1 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 618 Doctor Jack Road 21904 U.S.A. Funerai 11. Maritel Status 12. Wes Decedent Ever In U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: <u>۾</u> Specify: 3XXWidowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Twelve Years Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 9 Ella Gertrude Ramsey George E. Blackburn 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Hazel M. Patterson (Daughter) 1493-95 Clayton Street, P.O. Box 188, Perryville, Maryland 21903 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - Clty or Town, Stete Dete XXBuriel 2 Cremetion 3 Removal from State Hopewell Cemetery 7/20/98 Port Deposit, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name end Address of Facility
Lee A. Patterson & Son Funeral Home Perryville, Maryland 2190323a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. asmon 21903-0188 Approximete Intervel Between Onset end Deeth **Physician** /Medical MYOCARDIAL INFARCTION Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examine CARDIOUASCULAR DITTASS OIISCLE NOTIC law requires thet the death certificate be executed ettending physicien and lor use es the buriel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings evellable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed hes page 2 certificate 1 ☐ Yes XIX No 1 Yes 2 No Division of Vital Attanding Physician: funeral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 Yes 2XXNo Hospital: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending Investigation Naturel To the Hospital or Attanding within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun 2 Accident me, ferm, street, 28e. Place of Injury At hom building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide **XCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name end eddress of person who completed tause of death (Item 23a) (Type, Print) Charles S. Angell, M.D., 10755 Falls Road, Suite 200, Lutherville, Maryland 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUL 21 Julia Savidson

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 11:50 PM Julu ROBERTO ACOSTA NAVAT 4c. County of Deeth 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 24 Hrs. If Under 8. Date of Birth (Month, Dey, MAY 13, 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Hours 1952 Deys Months PHILIPPINES 227-78-9653 46 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL LAUREL Yes 2□No 10e. Street end Number 10f Zin Code 10g. Citizen of What Country? 8343 BROOK TREE STREET 20724 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Ves 2 □ No 1972 If Yes, Give Year or Detes: 1985 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married FILIPINO ™Yes 2 No Specify: FILIPINO Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 3+ COMMUNICATIONS SYSTEM ANALYST PRIVATE 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) ACOSTA LAURY NAVAT LIGAYA 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 906 SHELBY DR. OXON HILL, MD FORMER WIFE 20745 SHERRY NAVAT 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlal 2√ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) INURNMENT 1 ☐ Burlal 2 € Cremation 3 ☐ Rem ARLINGTON NATIONAL CEM. 8-5-1998 ARLINGTON, VIRGINIA 22. Name and Address of Facility MARSHALL 'S FUNERAL HOME Buscos Ton 4308 SUITLAND ROAD SUITLAND, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel 108 4 disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of) thet initiated events resulting in deeth) Last Due to (or es e consequença of): Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 24e. Wes en eutopsy 2 No 1 ☐ Yes 2 No 1 Yes 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Waturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end manner stated.

KMSER

29c. License number

PERMANENTE

29d. Dete signed (Month, Day, Year)

Box 68760, P.O. Division of Vital Records,

The law requires that the death certificate be-

Physician

/Medical

Examiner

Funeral

Director

or 28a-f ahow

Director

Funeral

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Completed

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Physician/Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahov any Injury or other traumatic event, The Musical Examiner inset by Indiffed anones.

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Certification: 24 hours a Funeral C Medical To the within 2 State

Registrar

MUTOMBU 31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

29a, Certifier

32. Registrer's Signeture

KAN KON DE

Kulk-De,

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O

			Certificate of	f Death	Re	g. No.	23309
	1. Decedant's Nama (First, Middla, Last)		HE THE HEAD		2. Data of Daeth Month		3. Time of Daeth
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To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		er: On the basis of examinat	wledge, death occurred et the				
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0	Al Jawad Waqas, M	.D. 11119 Ro	ockville Pike	, Suite 10	O, Rockv	ille, M	aryland 20852

Registrar

32. Registrer's Signatura

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

B a

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 23310 Certificate of Death Amended #4 P.G. G.C. 7/15/98 Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Day Month 7 **Physician** 98 Elaine Elizabeth Preston 10 11:20P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** P.G. Cheverly Prince Georges General Hospital If Under 24 Hrs. 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 4/8/1918 5. Social Security Number 6. Sex **Funeral** Hours Days Months 1 M 2 F 579-72-9149 Wash.D.C. 80 Director Usual Residence of Decedent with the Marylend permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at ences. 10a. State 10c. City, Town or Location 10d. Insida City Limits XXYes 2 No Director Washington D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20019 5219 Banks Place N.E. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: SpecifyBlack þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Statistician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Barbour Edward Matthew Russ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Code) 430 24th St. N.E. Wash.D.C.20002 Paula Baylor 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NDBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/16/98 Wash.D.C. Olivet Cemetery Mt. 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd.Suitland, md. 20746 Zawards 23a Purt1. Entar tha disaasa, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximete Intarval Batween Onset and Death Physician Staphy lococcal Sepsis /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner physician end s the burial-trensit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): of for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobecco use contribute to the cause of death? been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown Failure Respiratory by Encephalopathy 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed ciagosocis Hyportynidism
Organic Brain

25. Was case raferred to medical examiner? After this certificate has funeral director, pege 2 2 12 No Syndrome 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s efter deeth. ii Director: After this certificat ed in by the funeral director, p Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 2 1 Yas 2 No 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide the Hospital of the 24 hours effort Funeral DI 1 Cortifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier edical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

Mitcherulle

29c. Licensa number

D48213

7-12-98

220 BOWIE MD 20716

29b. Signature and title of certifier

TAHZA. N



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30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)

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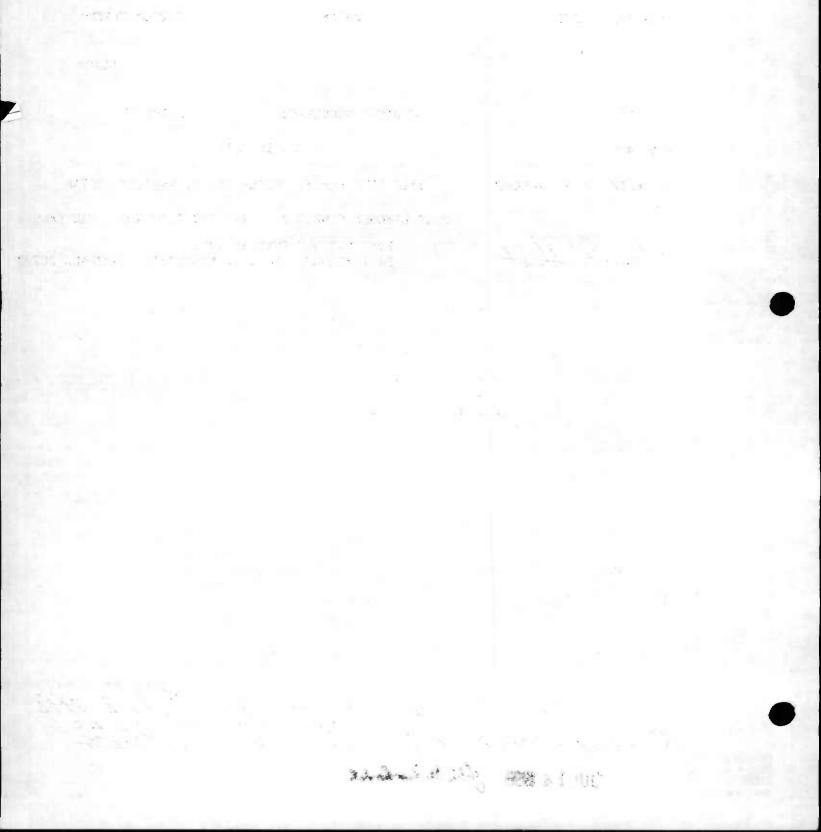
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	Tand 2: Health ar Bm 27 is other trau		20a. Method of Disposition 20b. Place of Disposition (N.	arne of	Dr. Suit	Date /	200. Location -	Olty or Toy	on, Stata
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurre 2 Medical Examiner: On the basis of axamination and/or investigation and mannar stated.	d at the	time, date and place opinion, death occu	and due to the	cause(s) and ma	nner as st	ated.
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			icate of i		Mental Hyo	leg. No.	23312
1. Decedent's Name (First, Middle, Last,	P		Pac	ot	2. Date of Dead Month	By /	3. Time of Death
4a Facility Name (If not institution, give 5. Social Security Number 6. Sec	Marylano		Under 1 Year lonths Days	If Under 24 Ars Hours Min.	on		of Death 9. Birthplace (State or Fore Country) NORTH CAROLIN
Usual Residence of Decedent 10a. State 10b. County		y, Town or Locati	on		THIR. 2	1,720	10d. Inside City Lim
MARYLAND PRINCE G	EORGE'S TE	MPLE HIL	J.S				1 ☐ Yes 2X)1
10e. Street and Number			10f. Zip Code			10g. Citizen of V	
3516 29TH PLACE 11. Marital Status 1 □ Never Married 2 🗓 Married	12. Was Decedent Ever in U,	S 13 Was	20748	ispanic Orlgin? (S	specify Yes or No-	UNITED	STATES - American Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		es, specify Cube Yes 2∑ No	ispanic Origin? (S an, Mexican, Puan Specify:	o Rican, etc.)	Specify:	k, White, etc.
15. Decedent's Edu (Specify only highest grad		(Give kind	's Usual Occup d of work done NOT use retired	during most of wo	rking	16b. Kind of Bu	siness/Industry
		MEDICA	L SECRE		me (First, Middle,	HOSPITA	
2 AMOS BUNN				MAGGIE		Maideri Sumem	a)
19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailing A	ddress (Streat	and Number or R		r, City or Town,	Stete, Zip Code)
LAURENCE PROUT, H 20a. Method of Disposition 1 X Burial 2 Cramation 3 F 4 Donetion 5 Other (Specify)	20b. Femoval from State	3516 29 Place of Disposition emetery, cremator RT LINCO	on (Name of ony or other place	e)	Date	20c. Location -	ND 20748 City or Town, State
231 P. 11. Enter the disease, or compleshook, or heart failure. List only or immediate Ceuse (Finel	cations that ceused the death the cause on each line.	340 h. Do not enter th	01 BLADI ne mode of dyir	g, such as cardia	RD., BREI	rest,	MARYLAND 207 Approximate Interval Between Onset and Dealth
disease or condition resulting In death)	Due to (c	or es e consequer	nce of):	Sill " C	er ing the	7 000	Gares 1/2
Sequentially list conditions, if any, leading to immediate	Due to (o	r as a consequer	nce of):				100
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Part II. Other significant conditions con	Lindes				10	ras 212 No	3 Probably 4 Unk
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25. Was case referred to medical examiner?	fospitel:	FB(0.4	3□ DOA Oth	001	eth (Check only o		(6
1 165 2 100	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	4 LI Nursing I	dome 5 ☐ Resident 28d. Describe I	ow injury occurr	
27. Manger of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At he building, etc. (Specification)	ome, farm, streat,	, fectory, office		28f. Location (S City or Tov	Street and Numb m, State)	er or Rurel Route Number,
29a. Certifier 12 Certifying Phys	alcian: To the best of my kno ner: On the bests of examine and manner stated.						
29b. Signature and title of certifier			29c. Licens	e number		29d. Date signer	d (Month, Day, Year)
K.P	angel	mo	D-	2564	10	Joly	8 1998
30. Name and address of person who co	mpleted ceuse of death (Item	1 23a) (Type, Prir	1328	South	ERN A	e. 0,	# 202
111021011	170/10/11 . 10	1.11.	111/	VIINGY	10/ 4-1	. /1	V 15-



Par strate Texasis estimates

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Daath 1. Decedant's Nama (First, Middla, Last, 3. Time of Death Month 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva straat end number) 4c. County of Death ask Hea P ant uno in mD If Under 1 Year | If Under 24 Hrs. 8. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) Days 2-52-27 Months Hours 1 □ M 2 1 F Yrs June 17, 1938 N. Carolina Usuai Rasidance ot Decedant 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Prince George's Maryland Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2509 Lewis Avenue 20746 USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ Mo If Yas, Giva 11. Meritai Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican indian. 1 Naver Merriad 2X Merried BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detas: 16e. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiamentery/Secondary (0-12) Coilega (1-4or 5+) 12th TEACHER / BUS DRIVER GOVERNMENT 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumeme) SIDNEY POWELL ROSA LEE SMITH 19a. Informant's Name/Raiationship (Type, Pnnt) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) ROBERT O. PATTERSON HUSBAND 2509 LEWIS AVE. SUITLAND, MD 20746 20a. Mathod of Disposition
1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramoval from Steta 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata cematary, cramatory or other place 4 ☐ Donation 5 ☐ Other (Specify) CAROLINA BIBLICAL GARDENS 7-13 RALEIGH, N. CAROLINA re of Funarai Sarvice License 22. Name end Addrass of Fecility MARSHALL'S FUNERAL HOME buscer. 4308 SUITLAND ROAD 10nic SUITLAND, MD 23a. Part1. Enter the disable, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailura. List only one causa on each line. Approximete Interval Between Onset and Death Immedieta Causa (Final disaase or condition rasulting in daath) Due to (or as a co 6 unente Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initieted avants rasulting in death) Last (or as a consequence of Dua to (or as a consequence of): Pert ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performad? 1 Yas 2 No 1 Yas 20 No 25. Was casa ratarred to medical 26. Piaca of Daath (Check only ona) examinar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28e. Data of injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28d. Dascribe how Injury occurred 28c. injury at Work? 1 Naturai

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

is marked other

ò Injury

permit. Pages 1 end 2 should be Department of Health and Mental Important: If Item 27 Is marked or

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

ettending physician and for use as the bunal-tran been signed by the should be detached

Examiner Physician/Medical à Completed Be 2 Certification:

2 Accidant

3 Suicida

29a. Certifiai

4 - Homicide

29b. Signature and title of certified

JUL 13 1998

The lew requires that the death certificate be executed is certificate has t director, page 2 s I or Attending Physician: after death. this funeral After Director: /

Division of Vital Records, P.O. Box 68760, the Hospital or Atternor 24 hours after de the Funeral Director political properties of the control of the cont To the

State Registrar

Medical

30. Name and eddrass of parson who complated cause ot death (itam 23a) (Type, Print) MI) ULI 31. Data tiled (Month, Day, Year)

5 Panding invastigation

6 Could not be determined

29c. Licansa number

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end mannar as steted.

1 Tas 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

3503 PERRY STREET, MOUNT RAINIER MOZONS

32. Registrer's Signatura

and mannar stated

28e. Place of injury - At homa, tarm, straat, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

None Post of the Section

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month **Physician** 2, PHYLLIS D. ROOK JULY 1998 2:30a.m. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nema (If not institution, giva street and number) Examiner Hospital Rockville Montgomery Shady Grove Adventist 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Yeer)

July, 25, 33 Birthplece (State or Foreign Country) **Funeral** Months 1□ M 2♥ F 228-76-1604 64 Director Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits pemit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If itsm 27 is merked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Mexical Examinat must be notified at ence. 10b. County 11 Yas 2□ No Va Emporia Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1558 Fish Rd. 238407 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. 1 ☐ Yes Z☐No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Restaurant 10 18. Mother's Nama (First, Middla, Meiden Sumeme) 17. Father's Name (First, Middle, Lest) Be Ned Thomas Lucy Hicks 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Albert Rook (Husband) 1558 Fish Rd., Emporia, Va. 238407 20b. Pleca of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Macedonia Bapt. Ch. 7/7/98 Emporia, Va. 22. Name and Address of Facility Central VA Funeral Services 21. Signatur of Fu aral Sarvice Licensaa P.O.Box 26528 Richmond, Va. 23261 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Myocardial infarction Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Atheroscleratic heart disease Physician/Medical Examiner attending physician end for use as the burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, hypertension Dua to (or as a consaquanca of): signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Chronic Renal Failure 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings evailable prior to complation of causa of death? 24e. Wes en eutopsy performed? Completed Dinbetes mellitus page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case rafarred to medical examinar? director. Be 26. Plece of Death (Check only one) Hospital: 1 Copatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yes 2 No 2 this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural er deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) filled in by Hospital or At 24 hours after of Funeral Direct 4 Homicide • Funeral 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted.

2 Medical Examiner on the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edicai 29e. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of burille D35703 no 30. Name and address of person was completed cause of deeth (Item 23e) (Type, Print) 6240 M on wose Pel Rock ill 7 m0 20152 Stephen Vaccares 32 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedant's Nama (First, Middla, La	est)		ertificate o		2. Data of De		3. Tima of Daath
	Orinda Morgan	Raynor				Month July	12, 19	998 10:20 p.m
/Medical Examiner	4a. Facility Nama (If not institution, gir				4b. City, Town, o	r Location of Deat		
Examiner	Holy Cross Hos	pital			Silver S	pring	Mon	tgomery
uneral rector		Sax 7. Aga 1□ M 2X F	(In yrs. last birthday 53 Yrs.	Months Day	r if Undar 24 Hi	s. 8. Data of Bi n. (Month, De	rth ay, Year) 9, 1945	9. Birthplaca (Stata or Foraign Country) Maryland
	Usual Rasidance of Decedant							
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ecto	Virginia Fairfa	x	Vier			1		1∭ Yas 2 No
Funeral Director	10e. Street and Number			10f. Zip Coda			10g. Citizan of	
- la	8321 Carneg				2180		U.S	
ů,	11. Marital Status	12. Was Decedant E Armed Forcas?	var in U,S. 13.	If Yas, specify Cu	Hispanic Origin? (ban, Maxican, Pue	(Specify Yas or No arto Rican, atc.)	D- 14. Had Blac	a - Amaricen Indian, ck, Whita, atc.
by F	1 ☐ Navar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorcad	1 ☐ Yas 2 🖔 No If Yas, Giva Yaar or Datas:		1 ☐ Yas 2 🗓 N	o Specify:		Specify	White
8	15. Decedant's E		16a Dece	edant's Usual Occ	unation		16h Kind of B	usinass/Industry
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To Be	Oscar Morgan				Cat	herine	Dobbins	
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	Troy Raynor - Hus				Drive,			
	20a. Mathod of Disposition	bana	20b. Placa of Disp			Data		City or Town, Stata
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	21. Signatura of Funaral Sarvice Lice			w Cemete		7/17/98	Atlant	a, Georgia
SUC	NOC	•		Gasch's I	Tuneral H	lome		
	W.D.G	erser	4	739 Balt	cimore Av	enue, Hy	attsvil:	le, MD 20781
	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	iplications that causad to ona causa on aach line	ha daath. Do not ar	ntar tha moda of d	ylng, such as cardi	ac or raspiratory a	rrest,	Approximata Intarval Batwaan Onset and Death
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al er	Immediata Causa (Final disaasa or condition rasulting in daath)	. Meta	Stanc	DYEC	art Co	ricer	WITH	
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Examiner	Sequantially list conditions, if any, leading to immediate	N/	ua to (or as a consa	quance of):				
	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury	. Pleur	a					
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Physician/I	Part II. Other algnificent conditions of	contributing to death but	not rasulting in tha	undarlying causa	givan in Part i.	23b. Dld	tobecco usa co	ntribute to the cause of death?
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l by							V0. 14. 630	045 246-11
ete						24a. was	an autopsy omad?	24b. Wara autopsy findings availabla prior to complation of causa
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2	1 ☐ Yas 2 X No	Hospital:	2 ER/Outpatie	nt 3 DOA	othar: 4 ☐ Nursing	Homa 5 ☐ Ras	ldanca 6 □Oth	ar (Specify)
Ë	27. Mannar of Death 1 △ Natural 5 ☐ Panding	28a. Data of Injury (Month, Day	Yaar) 28b. Tima o	of 28c. In	ury at ork?	28d. Dascribe	how injury occur	red
-	2 Accidant invastigatio			M 1	□Yas 2□No			
in in	3 ☐ Sulcida 6 ☐ Could not be datarmined		y - At homa, farm, st	traat, factory, offic	a		Straat and Numb	per or Rural Routa Numbar,
tificat								
Certificat		hysician: To the best of miner: On the basis of a	xamination and/or in	th occurred at tha nvastigation, in my	tima, data and pla opinion, daath oc	ce, and dua to tha currad at tha tima,	causa(s) and madata and place,	annar as stated. and dua to tha causa(s)
edical Certification:	29a. Cartifiar (Check only 2 Medical Exer	and mannar state		T	nsa number		29d. Data signa	d (Month Day Veer)
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pletely fill edical	29b. Signature and titla of certifiar 29b. Signature and titla of certifiar QON 30. Nama and addrass of parson who SQ Jeev Ananc 31. Data filed (Month, Day, Year)	naud, completed cause of dai	M, D, ath (Itam 23a) (Type 343A H s Signatura	D	-3348	32 ay, Gre	July 1	

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98-3874-033 jhm JENNIFER. ROBINSON

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State of Maryland / Department of H Certificate of

lealth and Mental Hygiene	0	8	2	2	2	1	6
Death Reg. No.	-	0	6	0	J	ı	

Physician /Medical Examiner

Funeral

Director

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item 27 is marked other than "natural", or flams 23a or 28a-f show other traumatic event, the Medical Exercion regat be notified at permit. Pagas 1 end 2 should be filed within 72 hours aftar. Department of Heelth end Mantal Hygiene. Important: If item 27 is marked other than "natural", or than any injury or other traumatic event, the Medical Evarient PADGS.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Physician/Medical Examiner requires that the death certificate be executed physician end s the buriel-trans P.O. Box 68760, use as tha signed by the a Division of Vital Records. page 2 should Completed peen hes Tha certificata Attending Physician: director Be 0 this funaral Certification: Aftar ar daeth. Hospital or At 24 hours efter of Funeral Direct filled in by 24 hours plately

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 07, Dex 1998 02:22 AM JENNIFER R. ROBINSON 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number) PRINCE GEORGES Temple Hills 2813 OXON PARK DRIVE if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yaer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days Hours Months 1□ M 2☑ F Yes Sept. 18, 1972 Washington, D.C. 577-90-6770 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside Cltv Limits 1 Yes 2 □ No Directo District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1377 Congress Street, S. E. 20032 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ó No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Sarah Wellington John Russ 2 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1377 Congress Street, S.E., Washington, D.C. 20032 Sarah Robinson - Mother 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 7/15/98 Landover, Maryland 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. 23a Port1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, mock, or heart failure. List only one ceuse on eech line. Approximata Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Gunshot Wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evidence) Due to (or es a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceusa of deeth? 24a. Was an autopsy 1 Ses 2 □ No Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Invastigation 1 Natural Injury 7 7198 100 AM 1 ☐ Yes 2 No subject shot 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stata) /506 Who for Pl. SEB! 3 Suicida 6 Could not ba determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end mariner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. Licansa number 29b. Signature and title of certifier OCME JULY 07, 1998

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Dey, Yaar) JUL 1 3 1998

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32. Registrar's Signature jahn Davetar Karle

30. Name and address of parson who completed cause of daath (Item 23a) (Typa, Print)

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DTMAS RIVERA State of Maryland / Depa

	2. Date of Death			3.	Tima	of E	Death
ificate of Death	Reg. No.	20	6	J	J		/
rtment of Health and M	Mental Hygiene	00	0	0	0	E	

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Tsidro

If Under 1 Year Months Days

2. Date of Death 09, 1998 Yaar JULY

Director

Funeral

by

Completed

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Examiner

Physician/Medical

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Completed

Be

To

Certification:

edical

4a Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death CHEVERLY

2:05P.M. 4c. County of Death

PRINCE GEORGES

Funeral Director

d other than "natural", or items 23s or 28s-f showevert, it a Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar Department of Health and Mental Hygians. Important: If item 27 is marked other than "natural; or ite eny findury or other traumatic event, Ita Menical Exprise eny findury or other traumatic event, Ita Menical Exprise.

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The law requires that the death certificate be axecuted

Records, P.O. Box 68760,

Division of Vital or Attending Physician:

death with the Maryland

589-68-5471 Usual Residence of Decedent 10a State 10b. County Prince Georges

10c. City, Town or Location

Yrs.

Takoma Park

7. Age (In vrs. last birthday)

41

if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 16,1957

 Birthplace (State or Foreign Country) El Salvador

10d. Inside City Limits

XXYes 2 No

MD

10e. Street and Number #4

6. Sex

★M 2□ F

10f. Zip Code 20912-5909 10g. Citizen of What Country?

6811 Red Top Rd.

5. Social Security Number

1 Never Married 2 Married 3 Widowed 4 Divorcad

Was Dacedant Evar in U,S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates:

College (1-4or 5+)

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Hours

14. Race - American Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

El Salvador

Specify:

9 years 17. Father's Name (First, Middle, Last)

Construction

A-L Abatement Inc. 18. Mother's Name (First, Middle, Maiden Sumame)

Filadelfo Rivera

Estevana Alfaro

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print)

14142 Victory Blvd. #217 Van Nuys, CA 91404

Guadalupe Joma 20e Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place) Santa Maria Cemetery 20c. Location - City or Town, Stata El Salvador

21, Signature of Governal Service Licens

22. Nama and Addrass of Facility Rendon/Hale Funeral Home

9013 Annapolis Rd. Lanham, MD 20706 enter the mode of dying, such as cardiac or respiratory arrast, complications that caused the death. Do not enter

Immediate Cause (Final disease or condition rasulting in daath)

Due to (or as a consequence of)

26. Plece of Death (Check only one)

UNKNOWN

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

24a. Was en eutopsy

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Intervel Between Onset and Death

Yes 2 No Yes 2□ No

25. Was case referred to medical 1 □XYes 2 □ No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Sulcide

4 Homicide

1 XInpatient 2 ER/Outpatient 3 DOA 5 Pending investigation

Date of Injury
Month, Day Year) 98 2030

Place of Injury - At home, farm, street, factory, offica building, efc. (Specify)

28c. Injury at Work? 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred M

accide 281. Location (Street and Number or Rural Route Number City or Town, State)

1-95, 1000 Crust

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fitle of cartifier

29c. License number

29d. Date signed (Month, Dav. Year)

6 Could not be determined

O.C.M.E.

JULY 11,1998

ress of person who completed cause of death (Item 23e) (Type, Print)

J. LARON LOCKE M 32. Registrar's Signatura 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

e en en en A. A. and an artist

Please Type or Print in Black Indelible ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23318 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey July 1, 1998 **Physician** JOHNNY ROBERTS 12:49 P.M. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SOUTHERN MARYLAND HOSPITAL Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F Yrs. Director 243-56-8053 59 Nov. 23, 1938 Creswell, N. C. Usuel Residenca of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show them 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Medical Examiner must be notified at 187 Yes 2 □ No Maryland Prince George's Directo Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7503 Surratts Road 20735 United States Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Introductant if them 27 is marked other than "natural", or free any injury or other treumatic event 1X Yes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Barber/Minister Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Edward Roberts Ethel Moore P 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) June A. Roberts - Wife 3355 Blaine Street, N. E., Washington, D.C. 20019 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, Stete © Burial 2 ☐ Cremetion 3 ☐ Removel from State Roberts Cemetery 7/9/98 Creswell, N.C. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility
STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C. 20019 23a Part1. Enter the disease, or complication block, or heart failure. List park one as Approximete Intervel Between Onset and Deeth is that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Physician immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. and physician a P.O. Box 68760. certificate be Physician/Medical that initiated events resulting in death) Last 2 Due to (or as a consequence of) 器 attending 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. adi bed 1 Yes 2 No 3 Probably 4 Unknown E aigned be del Division of Vital Records, À 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? PES **Page** 2 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) 0 1 Yes 2X No 1 | Inpatient 2 | XER/Outpatient 3 | DOA 4 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 X Natural 5 Pending death. 1 Yes 2 No investigation or Attend after death Director: 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

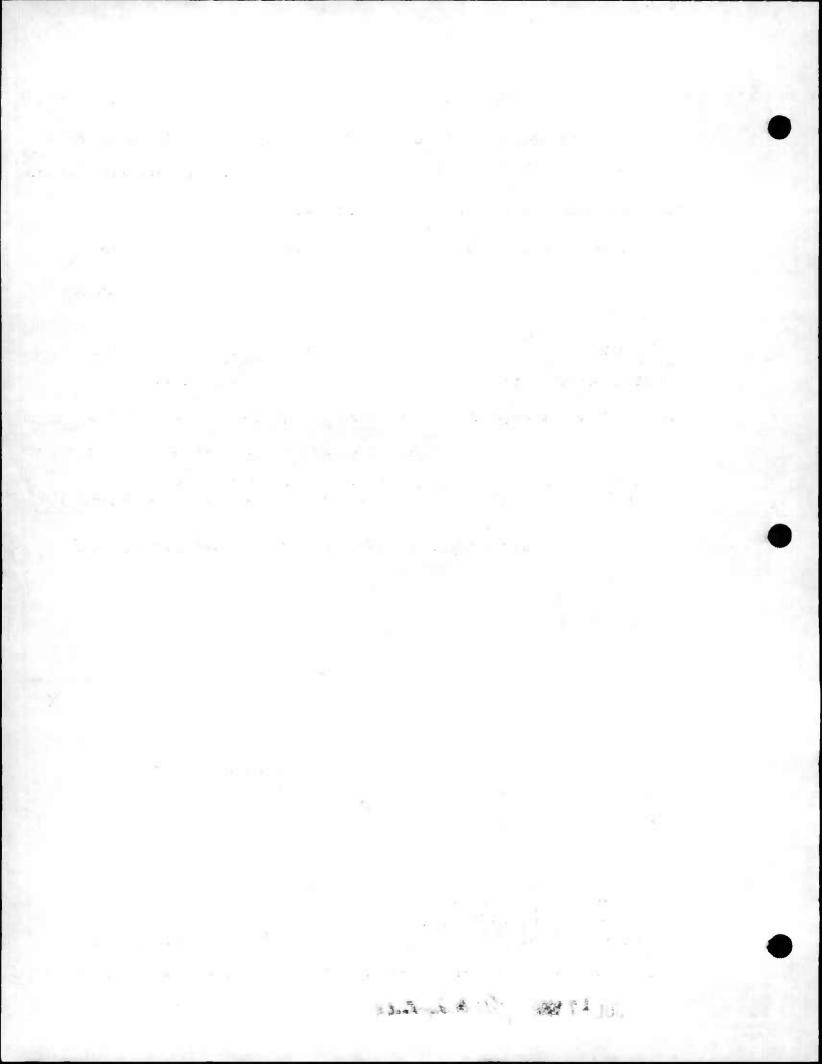
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier To the Within 2 To the and title of cert 295. Sign 29c. License number 29d. Date signed (Month, Day, Year) D14068 July 15, 1998 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Manoutchehr Moasser, M.D., 16005 Crain Highway, Brandywine, Maryland 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture 16, 1998 Registrar

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ng Address (Street an	18. Mothar's Name (First Birth	nt, Middla, Malden Sumame na Durham	
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sition (Name of natory or other placa)	Dat		City or Town, State
		7/98 Cheltenh	nam, Maryland
. Name and Address			7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
J. B. Jenl	kins Funera	al Home	Aryland 20785 Approximate Interval Batwaen Onsat and Death
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uenca of): uence of):			
nderlying cause givan	n in Parti. 2		tribute to the cause of death? 3 □ Probably 4 Vonknow
			^
	2	24a. Was an eutopsy performed?	24b. Were autopsy findings evallable prior to completion of cause of daath?
		1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
	26. Place of Death (Che	eck only ona)	
	4 Nursing Home	5 ☐ Rasidance 6 ☐ Othar Describe how Injury occurre	
DOA Other		ocation (Street end Number City or Town, State)	r or Rurel Route Number,
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ot 30 DOA Other 28c. Injury a Work? M 1 Ye eet, factory, offica	e, data and place, and du	tha time, date and placa, ar	(Month, Dev. Year)
DOA Other 28c. Injury a Work? M 1 Ye eet, factory, offica	e, data and place, and durinion, daath occurred at t	tha time, date and placa, and 29d. Date signed	
ot 30 DOA Other 28c. Injury a Work? M 1 Ye eet, factory, offica	e, data and place, and durinion, daath occurred at t	tha time, date and placa, and 29d. Date signed	
ot 3 DOA Other 28c. Injury a Work? M 1 Ye eet, factory, offica a occurred at tha time vastigation, in my opin 29c. License a	e, data and place, and durinion, daath occurred at t	tha time, date and placa, and 29d. Date signed	, 1998 11 LYVAND 2078
en of	Work	treet, factory, offica 28f. L	treet, factory, offica 28f. Location (Street end Number City or Town, State) th occurred at tha time, data and place, and dua to tha causa(s) and man exastigation, in my opinion, daath occurred at tha time, date and place, and control of the causa (s) and man exastigation, in my opinion, daath occurred at the time, date and place, and control of the causa (s) and man exastigation, in my opinion, daath occurred at the time, date and place, and control of the causa (s) and co



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State of Maryland / Department of Health and Mental Hygiene

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Examiner	4	a. Facility Name (If not institu Adventist Bra- Rehabilitat . Social Sacurity Number	ion (Center		ng and	If Under 1 Ya	Clin ar If Undar				e Ge	orges bleca (State or Foreign stry)
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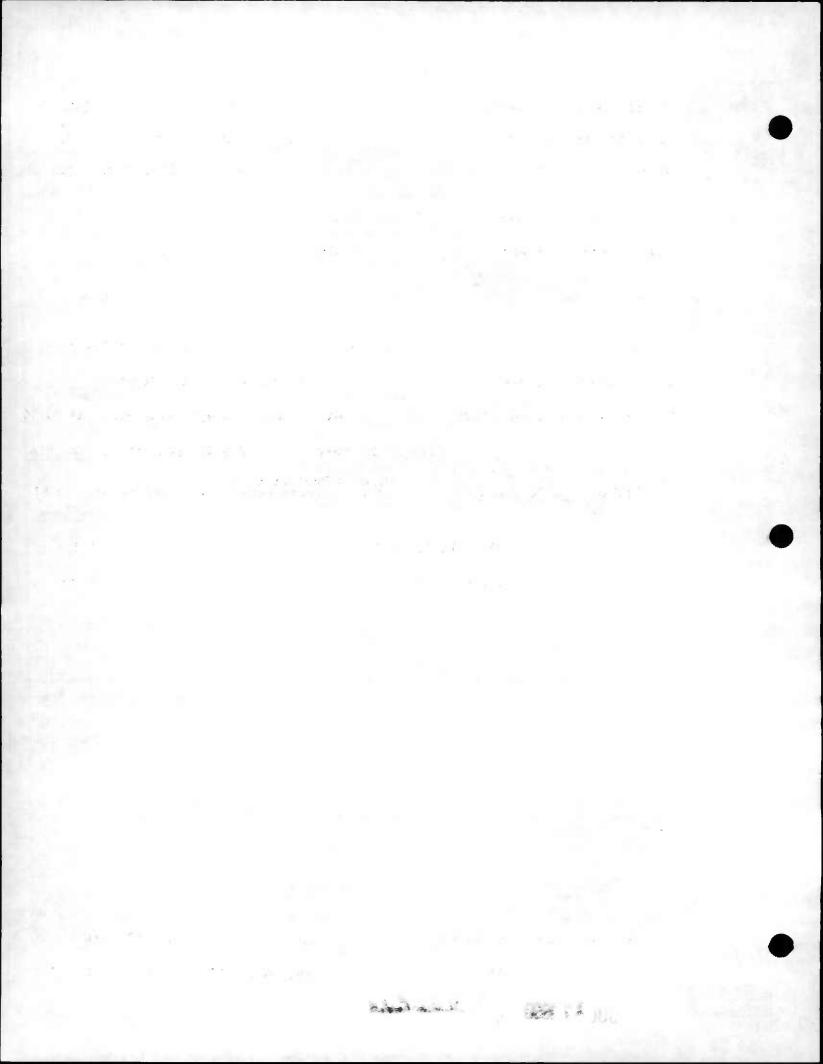
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State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security N 579-52-0)447	6. Ser	x] M 2□ F	7. Age (In yrs. 56		hday) If Unde Months	Days		8. Date of E	Birth Day, Year)	942	9. Birth	olece (Stete or F	oreign DC
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State of Maryland / Department of Health and Mental Hygiene 98 23323

				Certificat	e of	Death		Reg	J. No.		
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Physician /Medical	HOLTON RAMSAY	SMALL			1			ILY 8,	1998	1 4441	0420
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Be	17. Fathar's Nama (First, Middla, Las	it)				18. Mother	s Name (Firs	it, Middle, Mi	a <i>id</i> an Surnema	a)	
P	HAMILTON HOLTON	SMALL				NELL	IE OGI	E RAM	SAY		
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1	JOHN S. SMALL,	BROTHER	42	WEST D	EER	PARK R	D., GA	AITHER	SBURG,	MD	20877
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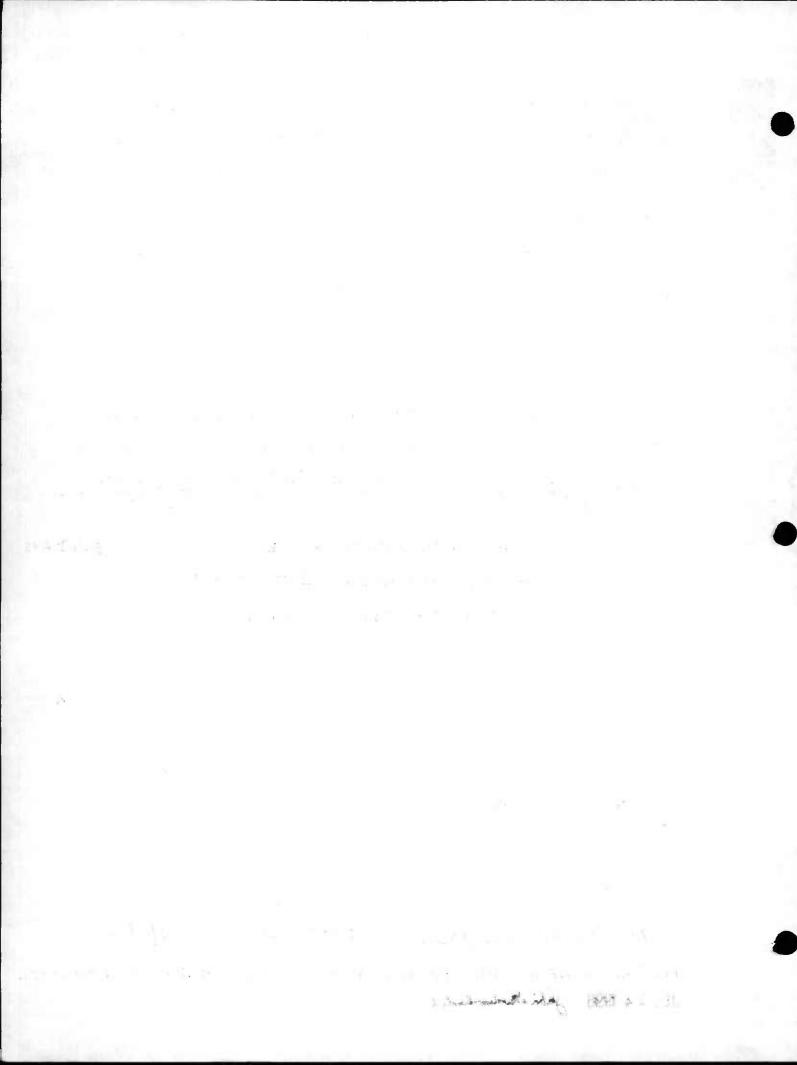
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Director	-				84	8 4 Yrs.						7/7/1	4	N	U. CA	ADCINA.
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niner must	5	1 Never Married 2 M	Armed Forces?			if Yes, specify Cuben, Mexic			en, Mexice	xicen, Puerto Rican, etc.)		10-	14. Race - American Indler Bleck, White, etc.			
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tre.		19a. Informant's Name/Reletionship (Type, Print) Mamie Clark/Friend							g Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo 3 rd Pl., N.W., Wash., D.C. 20011					de)		
9		20a. Method of Disposition	Tella	20h Place							T	20c. Location - City or Town, Stete		Ctoto		
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DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

JULY 09, 1998

State · Registrar

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30. Neme end address of person who completed ceuse

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32. Registrar's Signature

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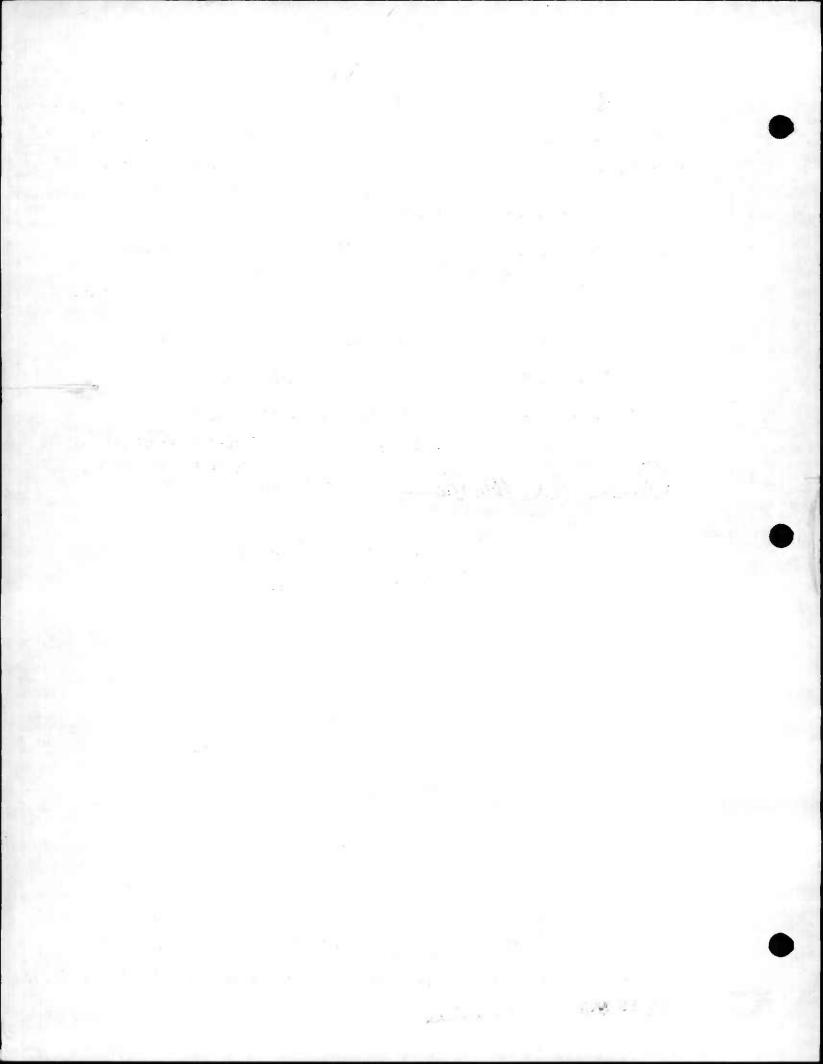
SHEET BURNER

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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121 William Showell

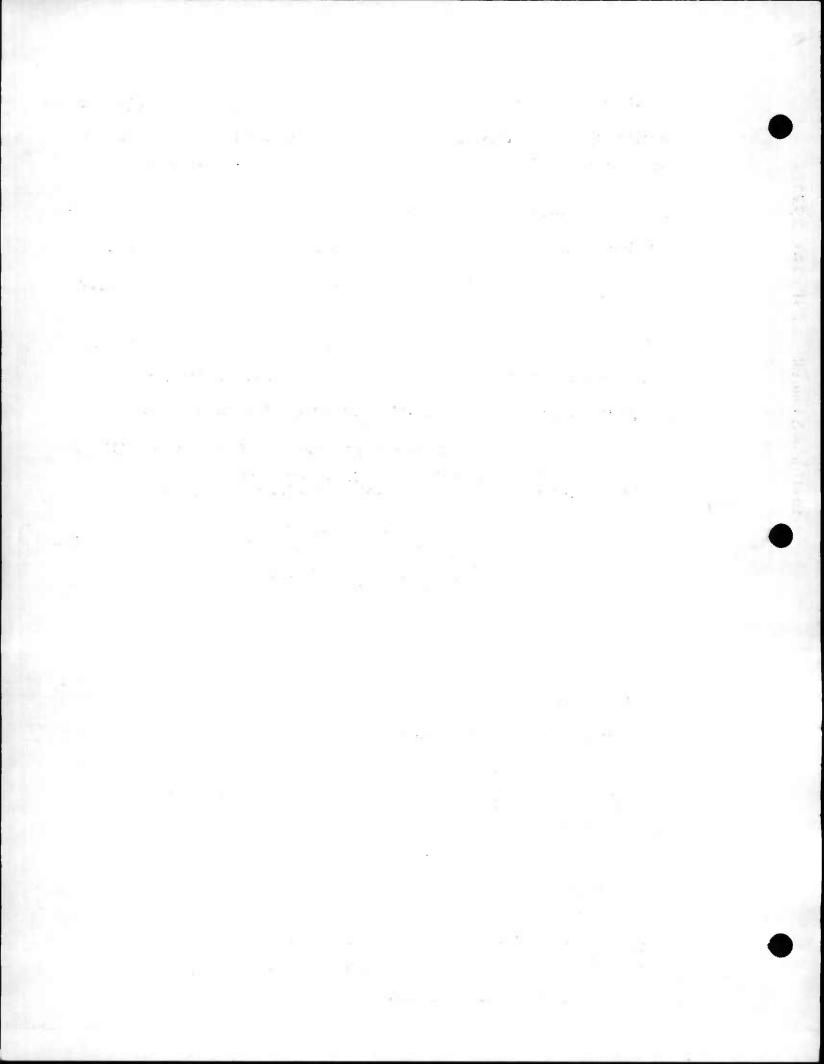
Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** William Showell, Jr. 4b. City, Town, or Location of Death 0800 1998 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 24 Hrs. Hours | Min. 6. Sex 1 → 2 F If Under 1 Year Birthplece (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 221-14-3972 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Depertment of Health and Mental Hygiene. Improctant: If Item 27 is marked other than "neturel", or frame 23a or 28a-f ahow any Injury or other traumatic event, the Medical Example or must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Flower St. 21811 U.S. Funeral 14. Raca - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6th Laborer Poultry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Showell Florence R. Showell 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Karen St., Suitland, MD 20746 Johnny Showell /son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - Clty or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 7/17/98 Whaleyville, MD Whalevville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvica Licensi 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23e. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart feilure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) 10 minutes Examiner Physician/Medical Examiner ovon ny ettending physician end for use as the bunel-transit The law requires that the death certificate be executed Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Stenosis à Aaiden t 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed (erebro vascola 24e. Wes en eutopsy ils certificate has t director, page 2 s Failure 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director; p. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA P 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 11X Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medicai 29a. Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and title of penifier 29c. License number JWy 8, 1998 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 201 tere Julin 32 Registrar's Signature 31. Date filed (Month, Day, Year)

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Registrar



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		17. Father's Name (First, Middle, Las George M. Tur		Jr.	Illia	18. Mother's Nar	me (First, Middle, M	(First, Middle, Maiden Sumame)		
Maryland		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Turrentine, Jr./Father 7317 Shady Glen Terrace Capitol Hgts.								
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State · Registrar

31. Dete filed (Month, Day, Year) JUL 13 1998

32. Registrer's Signature

completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

JULY 8,1998

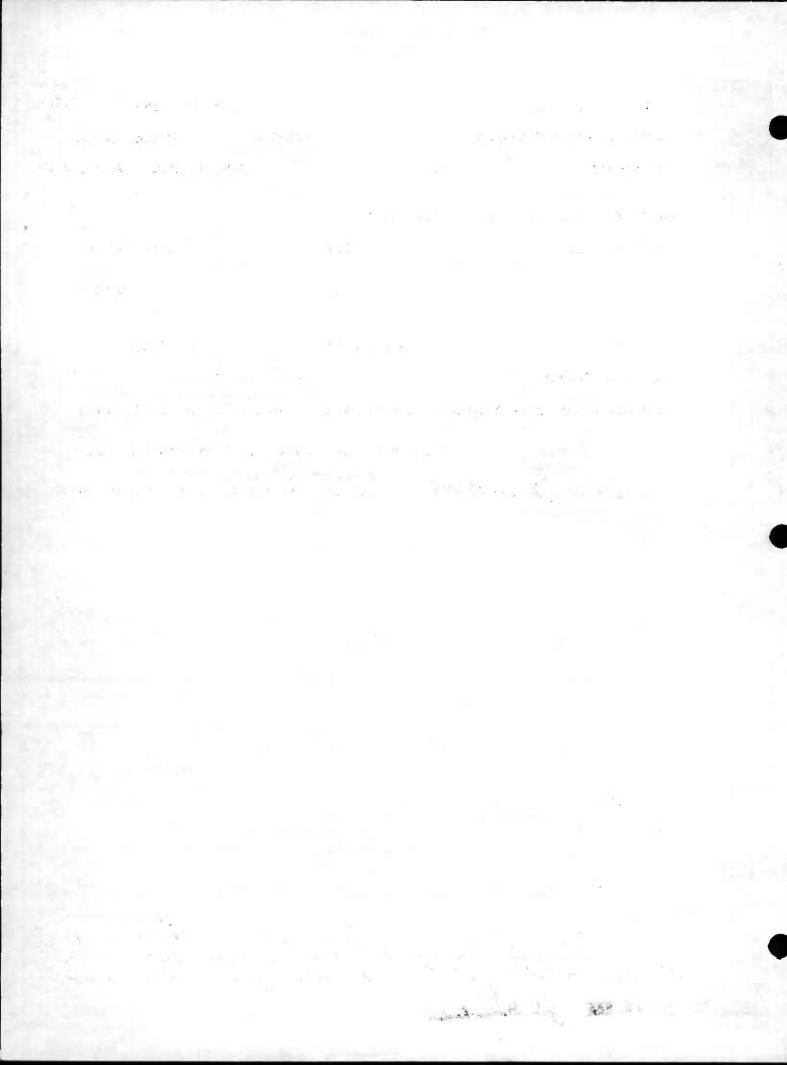
111 Penn Street, Baltimore, Maryland 21201

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 12, 1998 4c. County of Deeth 1998 JULY SUSTE MARY WRAY /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner 5409 ELMIRA LANHAM AVENUE PRINCE GEORGES if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 🛣 F 258-05-7967 90 Director 29, 1908 Georgia Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health and Mental Hygiene. Intropremit: If Item 27 Is merked other than "natural; or items 23s or 28s-1 show any injury or other treumatic event, in a Medical Examiner must be print. PROBLEM. 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Lanham Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5409 Elmira Avenue 20706 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Meritel Status 1 ☐ Yes 2 🔯 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Press Operator Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Johnnie Alston Wyche Mary 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary E. Greene / Daughter 5409 Elmira Avenue, Lanham, Maryland 20706 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Locetion - City or Town, State 07/17/ 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Maryland Nat. Mem. Cem. Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1998 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility J.B. JENKINS FUNERAL HOME Lowman Charles I 7474 Landover Road, Landover, Maryland 20785 23a. Part f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final BREAST CANCER diseese or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner attending physician end for use as the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. ALZHEIMERS DISEASE à 24b. Were eutopsy findings eveileble prior to should should 24e. Wes en eutopsy Completed completion of cause of deeth? his certificate has I 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 TYes 2 No deeth. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire completely filled in b 1 Cartifying Physician: 10 tile cost of examiner: On the basis of examiner and manner stated 29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. edical (Check only one) mination end/or investigetion, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) 29d. Date signed (Month, Dey, Year) 2 JULY 12, 1998 DME eted cause of dyam (Item 23a) (Type, Print) 30. Name end eddress of person who co DRIVE MARIO HOSPITAL 20785 32. Registrer's Signeture this being Registrar

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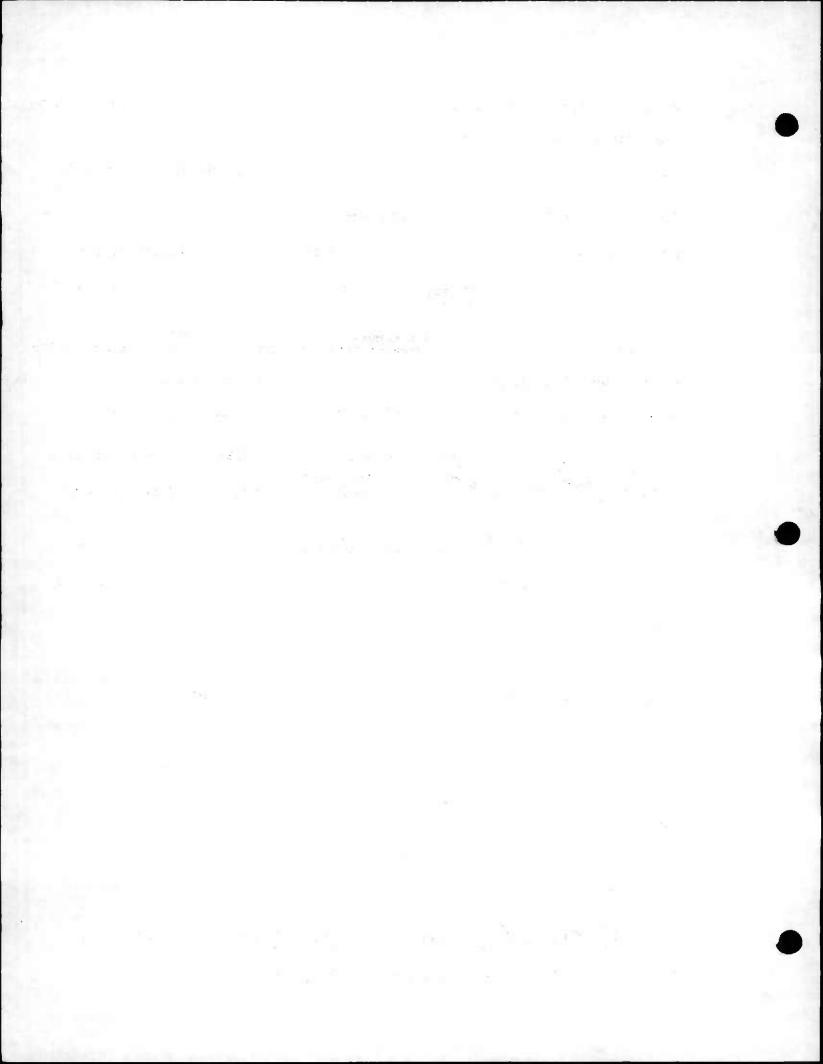
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** 4b. City, Town, or Location of Peath 16 1998 4c. County of Deeth Weller Collings Wilson, Sr. 03:11 7AM /Medical 4e. Fecility Neme (If not institution, give street and number) Examiner Union Hospital of Cecil County **Elkton** 8. Date of Birth (Month, Dey, Yeer) 5. Societ Security Number if Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** Deys Months Hours Director 213-16-0955 May 20, 1921 Maryland Usuel Residence of Decedent 10e. State 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner name be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☒ No Maryland Cecil Rising Sun 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 21911 death Funeral 519 Lombard Road 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Welfra Evant Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give US Ar Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Army þ Specify 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Union journeyman 11 steam-fitter / welder steam-fitter / welder 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be Mary Rebecca Purner William James Wilson, Sr. 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Stewart C. Wilson / Son 215 Old Zion Road, North East, MD 21901 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Harts Cemetery Elk Neck, Maryland 21. Signature of Funeral Server Lie 22. Name and Address of Facility
Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physiclan** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner requires that the death certificate be executed VRay 8 for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Due to (or es e consequence of) P.0. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? COPD Asbestosis 1 Yee 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were eutopsy findings evellable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? The 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Mennet of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After t **Division** 5 Pending investigation Injury s after death.

I Director: Aft
In by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide To the Hospital within 24 hours a To the Funeral C 117 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner steted. Medical 29a. Certifier completely 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) July 16, 1998 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Union Hospital Elkton, ND
32. Registrer's Signature

12+1VA

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 pm Amenio Anna July 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death University of Maryland Baltimore Baltimore City If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 7, 1927 If Under 1 Year Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) Days 1□M 2対F Yrs. Maryland 10c. City, Town or Location 10d. inside City Limits 10b. County 1 No Yes 2 No Baltimore City Baltimore 10f. Zin Code 10g. Citizen of What Country? U.S.A.

5. Social Security Number **Funeral** 220-12-4661 **Director** Usuat Residence of Decedent 10a. State Maryland Director 10e. Street and Number marked other than "natural", or items 23s or immite event, the Medical Examiner must be r 1026 West Cross Street 21230 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 전 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. ould be filed within 72 hours after Mental Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yas 2X No Specify: þ 3 DWidowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ex-Michael Kantor Mary Matsi 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Nutter/niece unknown 20b. Piace of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlai 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☒ Othar (Spacify) in State 21. Signature of Funerat Service Licensee Ronald S. Wade ²²State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part . Enter the disease or compilcations that caused shock, or haart failure. List only one cause on each lina Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical cerebrovascular accident Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by should 24a. Was an autopsy Completed his certificata has b

Approximate Intarvai Batween Onset and Death

3 days

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings aveilable prior to completion of cause of daath?

1 Yes 2 No

1 Yes 2 No

25. Was case raferred to medical 1 Yes 2 No

Hospitat: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 28b. Time of

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

Be

P

Certification:

edical

28a. Date of Injury (Month, Day Yeer) 5 Pending Invastigation 6 Could not be determined

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifie (Check only one)

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifian

29c. License number

29d. Date signed (Month, Dey, Year)

Marella Mura iela

AU 4176435-M8743 July 24 1998

26. Place of Death (Check only one)

30. Nama and addrass of person who complated cause of daath (ttem 23a) (Type, Print)

Marcella Mwaisela, University of Maryland, 22 S. Greene Street, Baltimore MD 21201-31. Data filed (Month, Dey, Year)

State Registrar

Physician

/Medical

Examiner

JUL 3 1 1998



28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)

or Attending Physician: after death.

Hospital

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Director: A

n 24 hours aftar dea ne Funeral Director

To the Hosp within 24 ho To the Fune completely fi

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State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of L	Death			Reg. No.	- Come	0000	,
		1. Decedent's Neme (First, Midd	lle, Last)		1 11					2. Date of De	eth Day	Year	3. Time of De	aath
	Physician / /Medical	Tony Allen Jr.								JULY	26, 199	8	0100	AM
Ŋ.	Examiner	4e Fecility Name (If not institution JOHNS HOPKINS		ber)			4	b. City, To BALT		cation of Death E	4c. Count	y of Death	hand a second and a second a s	
	uneral irector	5. Social Security Number 220-88-1161	6. Sex 7	. Age (In yrs. le	rest birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Month 10 / 31				8. Date of Bir (Month, De 10/31/7	of Birth th, Dey, Year) 9. Birthplece (State or Foreig Country) 1/72 Maryland			oreign	
20	2:-	Usual Residence of Decedent 10a. State 10b. County	,	10c City	, Town or Lo	ogtion			-			110	0d. Inside City	Limite
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the state of	or 28a-f s be notified Director	Maryland 10e. Street and Number		Ba	Baltimore 101. Zip Code					10g. Citizen of Whet Co			trv?	
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death	r items 23a iner must Funeral	1335 Homestead	12. Was Deced	lent Ever in U,S	3. 13.	Wes Deceder	nt of H	ispenic Ori	igin? (Spe	ecity Yes or No	- 14. Ra	ce - America		
5-0020 72 hours after death with the Marylend	by by	1 Never Married 2 Mail 3 Widowed 4 Divorce	If Yes, Give	es? If Yes, specify Cuban, Mexican, F No 1 ☐ Yes 2 ☑ No Specify:				Rican, etc.)		ack, White, e				
₹⊆	r than "		nt's Education est grade completed) College (1-4	bleted) 16a. Decedent's Usual (Give kind of work life. DO NOT use		l Occupation k done during most of working e retired)			Ing	16b. Kind of 8	Business/Ind	lustry		
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anc be fi	Pages 1 and 2 should be nent of Health end Mental ant: if item 27 la marked oury or other traumatic ever	17. Father's Name (First, Middle		18. Mother's Name					me)					
Tyle Mould		Tony Allen Sr.	abia (Tuna Briat)	19b. Mailing Address (St			24			chardso		State Zin	Codol	
Ma d2sl		19e. Informent's Name/Relation Donna Richards									Maryla Maryla			
The H		20e. Method of Disposition	on / nother			sition (Neme			, Dar	Date	20c. Location			
no ages		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 Removal from St	ate					0.0	/01/09	Woodlar	m Ma	rul and	
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Balt Permit.	any is		126		4	511 Par	rk i	Heigh	ts A	ve.,Bal	timore	, Mary	land 21	015
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68760,	Cal Cal	Ceuse (Disease or injury c.												
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B. Bo	hed for u	Pert II. Other significant conditi	ons contributing to dea	th but not resul	lting in the u	nderfylng cau	se giv	en in Pert i	1.	23b. Did tobecco use contribute to t			the cause of	death?
S, P.O	7 63								1	10	Yes 2□No	3 Prob	pably (X Ur	iknow
Vital Records, sicion: The law requires t	been s should leted										en eutopsy rmed?	eva	ere autopsy find allable prior to mpletion of cau deeth?	
The state of	sage 2									100	Yes 2 No	1 🕽	Yes 2□ No	0
ita	s certificate he director, page	25. Was case referred to medica examiner?	al					26. Plece	e of Deet	h (Check only o	one)			
of Vita Physician:	this ceral direction	1√Nes 2□ No	Hospital: 1 □ Inj	patient XXE	ER/Outpatle	nt 3 DOA	Oth	er: 4 🗆 Nu	ursing Ho	me 5□ Resi	denca 8 □O	ther (Specify	1)	
	= 20	27. Manner of Death 1 ☐ Naturel 5 ☐ Pendi	28a. Dete of (Month)	Injury Dey Year)	28b. Time o	280	. Injur	y et k?		28d. Describe	how Injury occu	irred	1	
Vision Attending	the fu		igation 7/20	6/98	0034	М		Yes 2	•	عيرو	ject	Sh	cot	
5 6 g	ed in b	4 Homicide determ	Stre	f Injury - At hor g, etc. (Specify)	1800	Block		E.E	Eage	City or Tot	Balt	imor	Route Numbe	L.
To the Hospital	he Funer pletely fill edical		ng Physician: To the b Examiner: On the bas and menne	is of exemination										
o the	Ne Me	29b. Signature and title of certific				29c. L	icens	e number			29d. Date sign	ed (Month, I	Dey, Year)	
7)	1 g. Pis	taner, 1	N.D.			.C.	M.E.			JULY 2	26, 19	98	
		30. Name and address of person	1		23a) (Type,	Print)	+	Balt	imon	e. Marv	land 21	201		
		JOSEPH T	estane	11		· JULCE	,			_, y				

State Registrar

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98-4253-510 Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. CMK Items: 10e, f per FState of Maryland / Department of Health and Mental Hygiene SARAH ALLEN ITEMS: #23 PART I, 27, 28 A-F G762 8-5-98 WR. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Yee **Physician** SARAH CATHERINE LLEA JULY 25, 1998 2000 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 2524 WEST FAYETTE STREET BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year Months Deys 8. Date of Birth (Month, Dey, Year) DEC. 02, 1909 Birthplece (Stete or Foreign Country) If Under 24 Hrs. 5. Sociel Security Number **Funeral** Hours 10 M 20 F 212-18-8371A Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at with the Meryle 1 PYes 2 No BALTIMORE Director MARYLAND 10g. Citizen of Whet Country? 10e. Street end Number 2524 West Fayette St 10f. Zip Code USA. Funeral 100 . Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status 1 Never Merried 2 Merried 1 Yes 2 No Maryland 21215-0020 Specify: BLACK Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 end 2 should be filled within 7 Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than °r Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER SELF-EMPLOYED UNKNOWN 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be AULTON HOWARD Lo 1 HOMAS MARTHA 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of cemetery, cremetory or other place) BALTIHORE MD. 21215

20c. Location - City or Town, Stete NEICE) Baltimore, 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 0 ALVARY CEMETERY 8-01-98 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) any injury 22. Name and Address of Fecility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIHORE, MD. 2/217 21. Signature of Funerei Service Licensee 200 Approximete Intervet Between Onset end Death nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, then tellure. List only one cause on each line. **Physician** THERMAL INJURIES /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest physicien end s the buriel-tran Due to (or es e consequence of): 8 Physician/Medicai Due to (or es e consequence of) USB BS signed by the el 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. o 1 Yes 2 No 3 Probabty 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed page 2 hes Yes 2 | No 1 Yes 2□ No certificate funeral director. 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA P 1 X Yes 2 No 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Certification: After 1 Netural 5 Pending investigation Injury SUBJECT VICTIM OF HOUSE FIRE efter death. Director: Aft 1 ☐ Yes 2 🕅 No UNKNOWN M 7-25-98 2X Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 HOME 2524 W. FAYETTE ST. 24 hours e Funerel D 29a. Certifier 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicat Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. (Check only one) To the I within 2 29d. Dete signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number JULY 26, 1998 O.C.M.E.

State Registrar 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

1998

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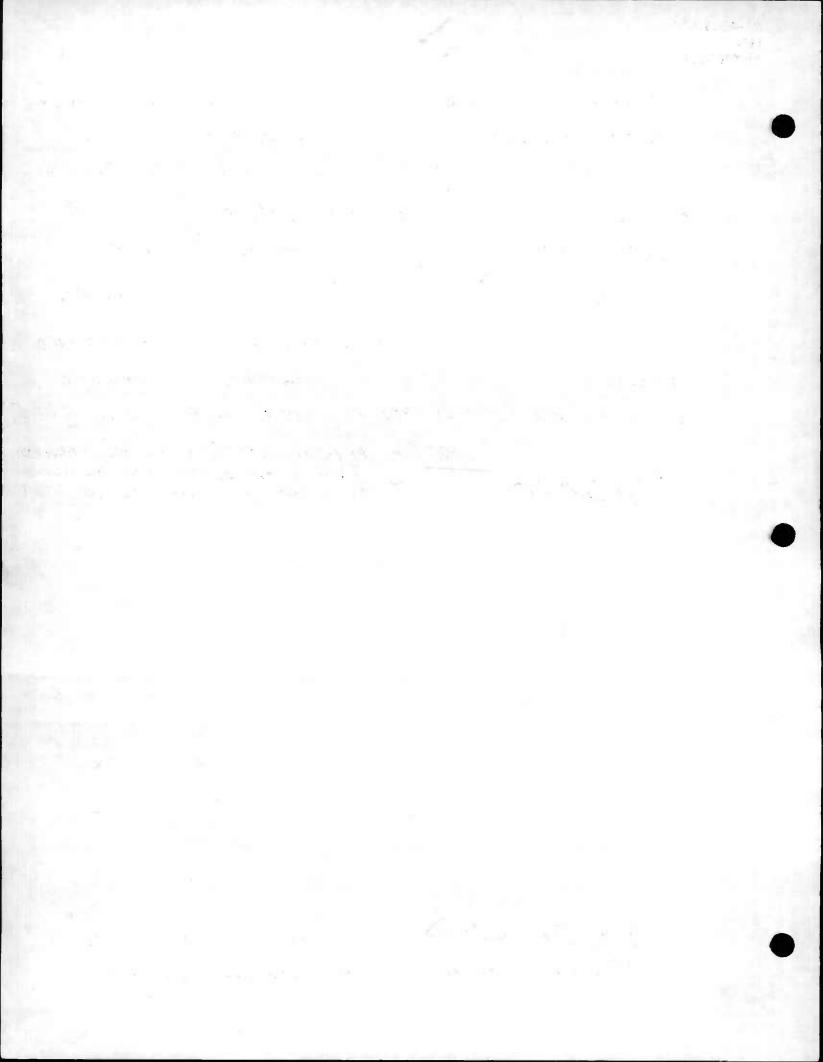
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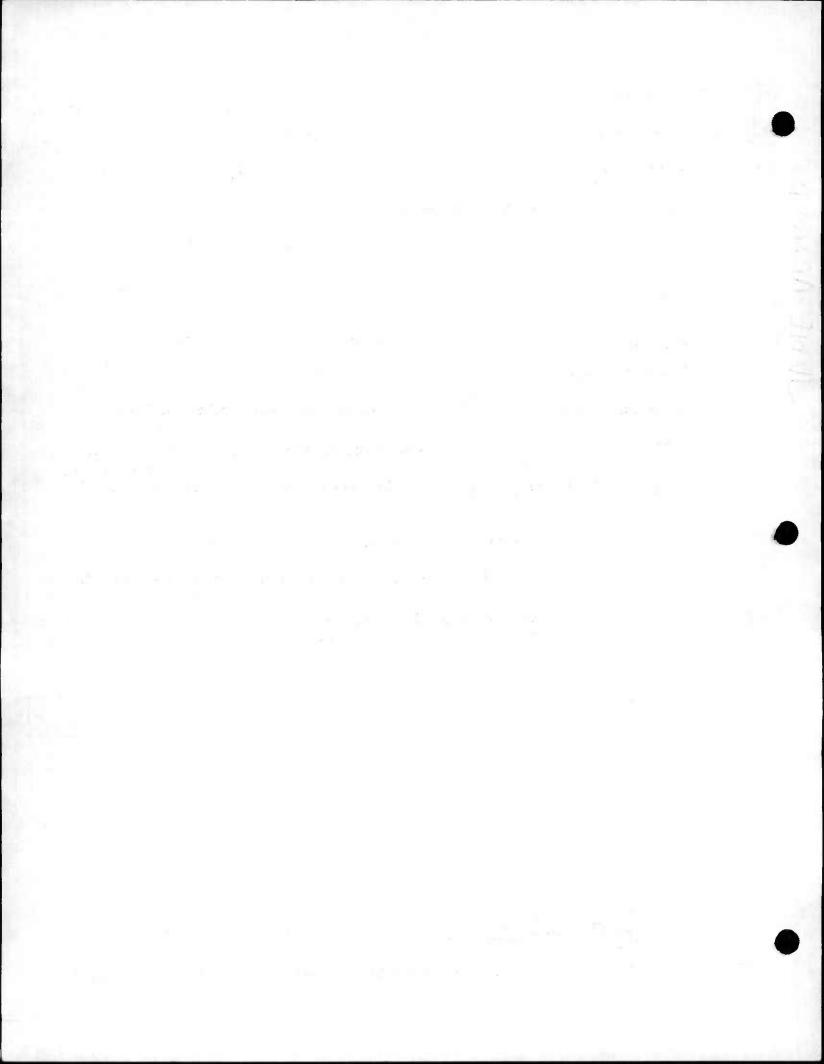
111 Penn Street, Baltimore, Maryland 21201



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Decedent's Nama (First, Middle Judie Arnold a. Facility Nama (If not institution Harbor Hospital) Social Sacurity Number 216–14–4775 Usual Rasidance of Decedant 10b. County Md. Anne	n, giva street and	number)				75	2. Data of D Month	Day 7 29 1	Yaar	Tima of Death
Harbor Hospital Social Sacurity Number 216-14-4775 Joual Rasidance of Decedant Oa. Stata 10b. County	6. Sex	number)				700		29. 1	998 2	•17 am
Harbor Hospital Social Sacurity Number 216-14-4775 Joual Rasidance of Decedant Oa. Stata 10b. County	6. Sex	number)					acation of Dos	th I do Count	of Death	· all
. Social Sacurity Number 216–14–4775 Jsual Rasidance of Decedant 0a. Stata 10b. County	6. Sex					b. City, Town, or L Baltimor		th 4c. County	n/a	
Jsual Rasidance of Decedant Oa. Stata 10b. County		7. Age (In yrs	. last birthday) Yrs.	If Undar 1 Months		If Undar 24 Hrs. Hours Min.	8. Data of B (Month, D Sept.	irth Pay, Year) 9, 1908		(Stata or Foraign
	201	. 05					sept.	9, 1900	N.C.	
id. Anne			ity, Town or Lo						10d. In	side City Llmlts
	Arundel	GJ	len Bur	nie					1	☐ Yes 3€No
^{0e. Street and Number} 1806 Jaki Terra	ce		10f. Zip Coda 21060					10g. Citizen of What Country? USA		
1. Marital Status 1 Navar Married 2 Marr 3 XVIdowed 4 Divorcad	ied 1 Ya	ecedant Evar in U Forces? s 25 No Giva r Datas:				spanic Origin? (Sp n, Maxican, Puarto Specify:	pecify Yas or N o Rican, atc.)		ca - Amarican Ind ck, Whita, atc. y:Black	dian,
(Specify only higha Elamantary/Secondary (0-12)	st grada complate									
	Last)	18. Mothar's Lula				18. Mothar's Nam Lula	ne (First, Middle			wn.
19a. Informant's Name/Ralations Ernestine A. Mi	hip (Type, Print)	daughter	19b. Mailin							1)
		m Stata	Place of Dispos cematary, cran	sition (Nama natory or oth	of ar place	9)	Data	20c. Location	City or Town, S	itata
	•	rek.	22	. Nama and	Addrass	s of Facility Nu	tter Fu	meral Ho	omes, In	nc. 216
m <i>m</i> ediate Causa (Final diseasa or condition asulting In daath)	Myoda. Hype	Dua to (Infai or as a conseq ve Art	rctio uance of): terio uanca of):	n -Sc	cleroti		iovasc	ular 1	at and Daath
Jausa (Disaasa or injury hat Initiated avants asulting in daath) Last	o.Cere Peri	ebrovas Dua to (c pheral	cular oras a consaqu Vascu	Acci uanca of): ular	den Dis	tease			3	years years
art II. Other significant condition	ns contributing to	death but not ras	sulting In tha un	ndartying cau	ısa giva	n in Part I.	23b. Dio	l tobacco usa co	ntributa to the	causa of death?
Seizure	Disorde	er					1□	Yes 2□ No	3 ☐ Probably	4 ⊠Unknown
							24a. Wa	s an autopsy formed?	available completi	atopsy findings a prior to ion of cause ?
							1□	Yes 2 No	1 🗆 Yas	2□ No
axaminar?	Hospital:				O.					
7. Mannar of Daeth ↑ Natural 5 □ Pandin	28a. Dai	ta of Injury	28b. Tima of Injury		. Injury Work	at ?				
3 Suicide 6 Could	not be 28a. Pla	ca of Injury - At h Iding, etc. (Spaci	oma, farm, stre	eet, fectory,				(Straet and Numb own, Stata)	par or Rural Rou	ta Number,
9a. Certifiar (Check only one) Certifyin 2 Medical	Examinar: On tha	basis of examina	owledge, death ation and/or inv	occurred at estigation, in	tha time	e, date and place, inion, daath occur	, and due to the rred at the time	a cause(s) and ma , data and placa,	anner as stated. and due to tha c	ause(s)
9b, Signature and attle of certifie	Malm	& mo	>	29c. l				-		Yaar)
	15. Deceden (Specify only higha: Elamantary/Secondary (0-12) ord Grade 7. Fathar's Nama (First, Middla, mmanuel McNeil 19a. Informant's Name/Ralations crossition A Middla, mmanuel McNeil 19a. Informant's Name/Ralations crossition A Middla, mmanuel McNeil 19a. Informant's Name/Ralations crossition A Middla, mmanuel McNeil 19a. Mathod of Disposition A Middla, mmanuel McNeil 19a. Mathod of Disposition A Middla, mmanuel McNeil 19a. Mathod of Disposition A Middla, mmanuel McNeil 19a. Part I. Enter tha diseasa, or shock, or heart failura. List mmediate Causa (Final diseasa or condition asulting in death) 19a. Part I. Enter tha diseasa, or shock, or heart failura. List mmediate Causa (Final diseasa or condition asulting in death) 19a. Part I. Enter tha diseasa, or shock, or heart failura. List mmediate Causa (Final diseasa or injury hat initiated avants asulting in death) Last 19a. Captiliar Jaccident Space of Medical dearm (Check only one) 19b. Signature and addrass of parson on the manual diseasa or parson on the middle of cartifies one) 19b. Signature and addrass of parson on the middle of cartifies one of the middle of cartifies one of the middle of cartifies one of the middle of cartifies one of the middle of cartifies one of the middle of cartifies one of the middle of cartifies one of the middle of cartifies one of the middle of the midd	15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's grada complate 15. Decedent's Print 15. Decedent's Print 15. Decedent's Print 15. Decedent's Print 15. Decedent 15. Deced	15. Decedent's Education (Specify only highast grada completed)	15. Decedent's Education (Specify only highast grade complated) 16a. Daced (Giva lina. Least) 16a. Daced (Giva lina. Lea	15. Decedent's Education (Specify only highast grads complated) 16a. Decedent's Usual (Biva kind of work Home Maker Collaga (1-4or 5+) 16a. Decedent's Usual (Biva kind of work Home Maker Collaga (1-4or 5+) 16a. Decedent's Usual (Biva kind of work Home Maker Collaga (1-4or 5+) 16b. Mailing Addrass (7806 Jaki Tomestine A. Mills	15. Decedant's Education (Specify only highest grade complated) Elemantary/Secondary (0-12) Ind Grade 7. Fathar's Nama (First, Middla, Last) Immanuel McNeil 19a. Informant's Name/Ralationship (Type, Print) daughter Immanuel McNeil 19a. Informant's Name/Ralationship (Type, Print) daughter Immanuel McNeil 19b. Malling Addrass (Straat a) 7806 Jaki Terry: Immanuel 2 Cramation 3 Ramoval from Stata A Donation 5 Othar (Specify) 11. Signatura of Funeral Sarvice Licenses 220. Part Lenter tha disasas, or complications that Just the death. Do not antar tha mode of dying shock, or heart failura. List only one cause of escalarine. Myocardial Infarction Sausa. Enter Underlying auss. Enter Underlying a	Second S	Second S	15. Decedent's Education 15. Decedent's Educ	15. Decedent's Education Vasa or Dates:

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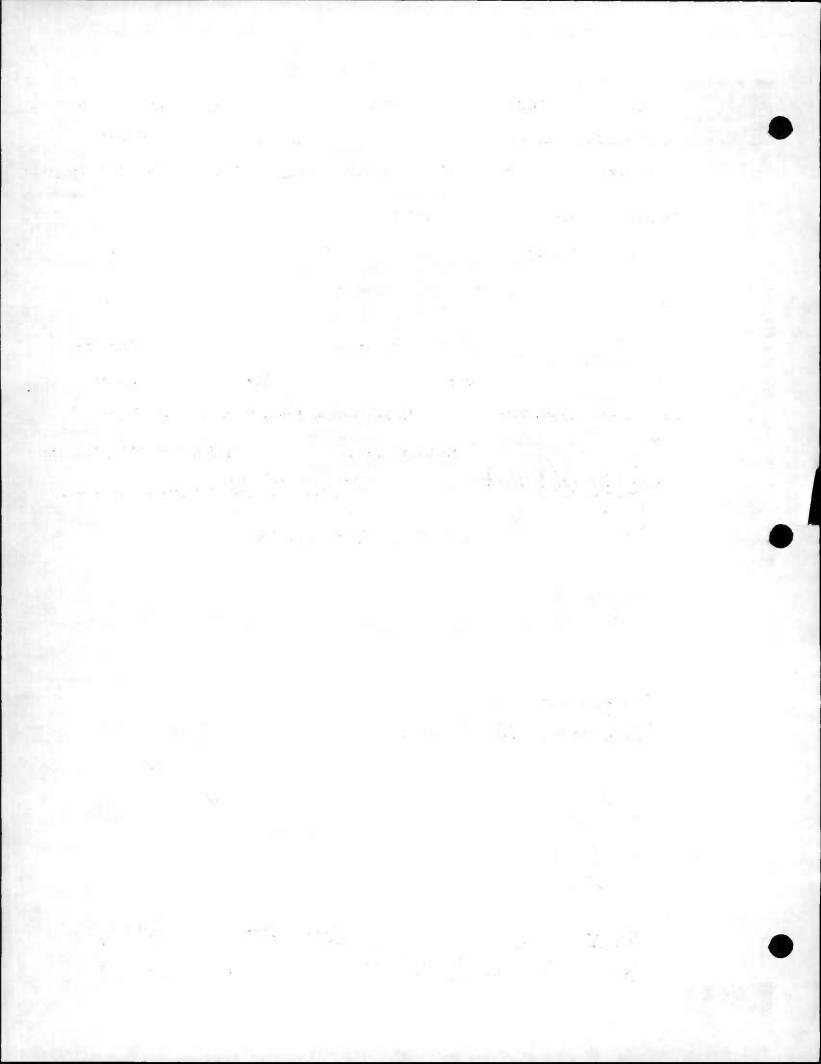
			Ce	rtificate of	Death	Re	g. No.	2	3336
ysician	1. Decedent's Neme (First, Mid	die, Last)				2. Dete of Deeth Month	Day	Yeer	3. Time of Death
dical	John	Charles		Ahlberg		July 30			4:30am
iner	4e Fecility Name (If not institut	ion, give street end number)			4b. City, Town, or Loc	ation of Deeth	4c. County	of Deeth	
	13 Collis Co				Timonium			imore	
	5. Social Security Number 520-30-3570	6. Sex 7. Age (III	n yrs. lest birthday Yrs.	Months Days	r If Under 24 Hrs. s Hours Min.	8. Dete of Birth (Month, Day, May 31,		9. Birthplec Country, Wyom	ce (Stete or Foreign) ning
	Usual Residence of Decedent	Lao	0: 7					40.1	
_	10e. Stete 10b. Coun	ly 10	c. City, Town or L					106.	Inside City Limits 1 ☐ Yes 2 📆 No
5		timore	Timoni				10g. Citizen of Whet Country?		
Director	10e. Street and Number			10f. Zip Code		10			17
	13 Collis Co				.093		USA		
	11. Maritel Stetus	12. Wes Decedent Eve Armed Forces?	r In U,S. 13.	Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto F	cify Yes or No- Rican, etc.)		- American k, White, etc	
	1 Never Married 2 M Mi 3 Widowed 4 Divorce	If Yes, Give		1 ☐ Yes 2 📉 No	o Specify:		Specify:	Whi	.te
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	12 17. Fether's Name (First, Middl	5+	M	lanagemen	18. Mother's Name	(First Middle M			Company
			41.11						
	Victor	Aaron	Ahlber		Madelin			wford	
	19a. Informant's Name/Reletio				et end Number or Rurai				ode)
	20a. Method of Disposition	Ahlberg/Wife	20h Dinne of Dien	neition (Name of	court, Timo		2109 Oc. Location -		Stoto
		3 Removal from Stete	cemetery, cre	emetory or other pl	@Crematory	Date	OC. LOCATION	City of Town	1, 31818
	4 □ Donation 5 □ Other	(Specify)	Baltimore	-Washing	ton 7	/31/98	Laurel	, Mary	yland
	21. Signature of Funeral Service	a Liberghal O Co N . 1		22. Name and Add	ress of Fecility Tuneral Home	0			
į	Bryan W.	Clary	1		donia Road		ium. MD	2109	93
cian		or complications that caused the st only one cause of each line.	death. Do not er					A	pproximete
	snock, dignear raylare. Li	st only one cause on eech ine.						Ö	ntervei Between Inset end Deeth
	Immediate Cause (Final	11. 1.		. 1/.	Ann	167			
	Immediate Cause (Final disease or condition resulting in death) e. (ardiorespiratory Arrest Due to (or es a/consequenca of): Hetastatic Cabbrain								
		Ha / Due	e to (or es a/conse	equenca of):	11.	,			
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1	if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	C						i	
1	thet initieted events resulting in death) Last	Due	to (or es e conse	quenca of):					
		d.							
	Station 1					l est series			
	Part II. Other significant condi	tions contributing to deeth but n							he cause of death
	Lulmonar	y Inter	stiti	a1 4	610515	1 Y	s 2 No	3 □ Probal	bly 4 Unknow
completed by ringsicially	B /	1, 11				24a. Wes er	autoney	24h Were	eutopsy findings
-	10 ronch	al asth.	ma			perform	ned?	comp	ebie prior to pletion of cause
-								of de	eth?
						1 ☐ Ye	s 2 X No	101	Yes 2□ No
	25. Was case referred to medic examiner?				26. Place of Death	(Check only on	е)		
	examiner? 1 ☐ Yes 2 🗶 No	Hospitel: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA	Other: 4 Nursing Hon	ne 5 K Reside	nce 6 Othe	er (Specify)	
	27. Manner of Deeth	28e. Dete of Injury				8d. Describe ho			
	1 XNeturel 5 Pend 2 Accident Inves	tigation (Nontri, Dey 18	9ar) Injury		☐ Yes 2☐ No				
	3 ☐ Suicide 6 ☐ Coul	mined 200. Placa of injury	- At home, farm, s	treet, factory, office	e 2	8f. Location (St.	reet end Numb	er or Rurel P	Route Number,
	4 Homicide	building, etc. (5	opecify)			City or Town	, State)		
	29a. Certifier 1 X Certify	ing Physicien: To the best of m	v knowledge, dee	th occurred at the	time, date end plece A	nd due to the ce	ouse(s) end me	nner es stat	ed.
		al Exeminer: On the besis of exa	aminetion end/or in						
	29b. Signature and title of Cent	,		29c. Lice	nse number	2	9d. Date signed	d (Month. De	ey, Year)
	h 1/7	/	>	< 5	2 0				
	100	un		DV1	2733		auth	31, 19	770
	30. Name and address of perso	n who completed cause of death	(Nam 23a) (Type	, Print)					
	Sami Brahim	, MD 7620 Yo		Baltimo	re, Maryla	nd 212	04		
	31. Date filed (Month, Day, Yes	32. Registrer's	Signeture						
	JOE 6	1 1998 Julia	Davidson-V	andelle					

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State of Maryland / Department of Health and Mental Hygiene

				Certificat	e of	Death		,	Reg. No.	6- 1	3331
	1. Decedent's Neme (First, Midd	le, Last)						2. Date of Dea	ath	Voor	3. Tima of Death
Physician /Medical	IDA	FREED		ADAMS				July 2	9, 1998	Year	5:19am
Examiner	4a Fecility Name (If not institution	n, give street and number	7)			4b. City, To	own, or Lo	cation of Death	4c. County	of Deeth	1,-1
(2210 Larchmon	Drive				Fal	lsto	n	Har	ford	
Funeral	5. Social Security Number		ge (in yrs. last b	Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Data of Birt (Month, Da	h y, Year)	9. Birthple Count	ace (State or Foreign
Director	217-12-3215	1□M 2∏F	90	Yrs.							Virginia
P .	Usual Residenca of Decedent 10a. State 10b. County		10c City To	wn or Location						10	Od. Inside City Limits
aho aho											1 ☐ Yas 2 ☑ No
vith the Ma	Maryland Hart	ord	Fa	llston 10f. Zip Code					10g. Citizen of Whet Country?		
Dir Dir	10e. Street and Number	2.950 81		101. 210		0.4.7			-		uryr
a 23	2210 Larchmont	Drive 12. Was Deceden	t Ever in II C	21047						USA e - America	an indian
ufter death v r ftema 234 niner mant	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed Forces	?	,S. 13. Was Decedent of Hispanic Origin? (Sp. If Yas, specify Cuban, Mexican, Puerto			n, Puerto	Rican, etc.)	Blac	ck, White, e	
11.21.5-0020 within 72 hours after death with the Maryland ane. then. then are instituted, or items 23s or 28s-4 show the Marical Everyliner must be notified at ampleted by Funeral Director	3 ₩ Widowed 4 Divorced	If Yas, Give		1□ Yes	2 ₹ No	Specify	:		Specify	Whi	to
Po Poor	15. Deceder	nt's Education	16	a. Decedent's Usua	al Occup	petion	J.,		16b. Kind of B		
1 2121 5-0 led within 72 ho tygiene. The Medical Completed	(Specify only higher	st grade completed)	.6.1	(Give kind of wo	rk done se retire	during mos d)	st of worki	ing			
with a mo	Elementary/Secondary (0-12)	College (1-4or		Homemake	er					Own H	ome
be filed tal Hygi d other event, I	17. Fathar's Nama (First, Middle,	Last)		18. Mother's Name (First, Mid					Malden Suman	10)	
ylan build be f Mental I mrked of artic eve	Walter	mory			Ida		M	iller			
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mantal hygiene. 7 Is marked other than "natural", or traumatic event, the Medical Event To Be Completed by F	19a. Informant's Name/Relations	ship (Type, Print)	19	b. Mailing Address	S (Street	and Numb	er or Rure	al Routa Numbe	er, City or Town,	State, Zip	Code)
1 and 2 1 and 2 Health at mm 27 is other trau	Jean J. Kohler	/Daughter	2	13 Falls	broo	k Roa	d, T	imonium	, MD 2	1093	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any highy or other traumatic event, the Medical Evarinet must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition		cemat	of Disposition (Nar	me of other pla	ce)		Date	20c. Location -	City or To	wn, State
Pages nent of nt: If he nry or o	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		9	ood Cemet			07	7/31/98	Parkvi	lle, N	Maryland
Baltimore, permit. Pages 1 at Depertment of Hea Important: If Item; any injury or othe	21 Signature of Funeral Service	Lifogiffe 1		22. Name ar	nd Addra		ity				
Depen Permission of the Permis	Bryan	Cluses				Funer			ondum	MD 2	1093
	23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										Approximate
Physician	shoot, or heart failure. List				-					1	Onset and Death
/Medical	Immediate Cause (Final disease or condition										
Examiner	disease of control resulting in death)										
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be executed sician and bunal-transit	Convention list conditions	b	Due to (or as a	consequence of):						- !	
owecuted an and rial-transit	if any, leading to immediate		Due to (or as a	consequence on.							
oo / bu,	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or es a	consequence of):				-			
	resulting in death) Last Due to (or es a consequence of):										
box ath cent for up and	d										
ds, F.O. 500 ires that the death of signed by the attend d be deteched for the draw d by Physician/	Part II. Other significant conditi-	ona contributing to death	but not resulting	in the underiving of	cause di	ven in Part	I.	23b. Did	tobacco use co	ntribute to	the ceuse of death?
et the de di by the de eteched								23b. Did tobacco use contribut			11
S, F es the igned be de	Supert	PISIOPI									
The law requires that the death of the law requires that the death of the athor page 2 should be detected for un Completed by Physician/	Dinine	ension ies Mel	1,41	2					an autopsy	24b. We	re autopsy findings
w requires s been 2 should	Munc	123 /1101	1 / 000	3				perio	1111001	cor	npletion of cause death?
The law require tete has been single 2 should Completed								10	res 2000	1	Yes 2000
Altai Slan: T Setor, p Be C	25. Wes case referred to medica	1				26 Plac	e of Deatl	h (Chack only)	111111111111111111111111111111111111111		
INVISION OF VITAL HECOPICS, for Attending Physician: The law requires the after creating. The law requires the after creating of the funeral director, page 2 should be call by the funeral director, page 2 should be call the funeral director.	examiner?	Hospital: 1 ☐ Inpat	ient 2 ER/C	Outpatient 3 DC	OA Oth	nor:	ursing Ho		dence 6 □Ott	er (Specify	<i>'</i>)
Physical of the Physical of th	27. Manner of Deeth	28a. Date of inj	ury 28b	Time of	28c. Inju Wo				how injury occur	1-1-7	,
atto	1 Natural 5 Pendii		ay rear)	Injury		Yes 2□	No				
UNISION or Attending lefter death. Director: After in by the fune	3 Suicide 6 Could 4 Homloide datem	nined 286. Place of Ir	njury - At home,	farm, street, factor	y, office					er or Rura	Routa Number,
DIVISION C bei or Attending P rs effer death. al Director: Affer t led in by the funers Certification:	4 LI Homicide	building, e	tc. (Specify)					City or To	vii, State)		
splus hours nera y fille		ng Physicien: To the best									
DIVISION OF VITAL HER INC. To the Hospital or Attending Physician: The law within 24 burus eiter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	(Check only 2 Medical one)	Examiner: On the basis of and manner s		nd/or investigation	, in my	opinion, de	ath occurr	ed at the time,	date and place,	and due to	the cause(s)
withir To th comp	29b. Signature and title of certifie	or .		29	c. Licens	sa number			29d. Dete signe	d (Month, I	Day, Year)
	1 200 Cla	Aug			0	44	27	1	71	30/	98
10	30. Name and address of person	who completed cause of	death (Item 23e) (Type, Print)_				•			
	35 F.	Padoni	a Ro	1	nor	VIL	m.	MA	210	93	
State	31. Date filed (Month, Day, Year,	32. Regist	trar's Signature								
Registrar	20F 3T 1	998 garia	Davidson-	Randelle.							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Months

TOTAL T	г т	TTKT	
C. I.		AH	

ITEMS: #23 PART I, II, 27, PER MEO G762

N/A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Baltimore

10f. Zip Code

N/A

10g. Citizen of What Country?

Physician
* /Medica
Examine

BROUGHTON

1. Decedent's Name (First, Middle, Last) Elijah Broughton Jr.

1∏M 2□F

2. Date of Death Month JULY

27.

4a Fecility Neme (If not institution, giva streat and number) 2219 BROOKFIELD AVE

4b. City, Town, or Location of Deeth BALTIMORE

21217

1998 5:55A.M. 4c. County of Death

Funeral Director

250-96-9894 Usual Residence of Decedent 10a. State 10b. County

5. Social Security Number

10c. City, Town or Location

Yrs

7. Age (In yrs. lest birthday)

43

If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month Day, Yeer) 54

 Birthplace (Stete or Foreign Country) SC.

10d. Inside City Limits

Xes 2□No

10e. Street and Number 2219 Brookfield Avenue

Director Funeral g Completed

with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic svent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Introprent: If them 27 is marked other than "natural", or its any finity or other traumatic avant, if a Mental Examina

Maryland 21215-0020

Baltimore.

Physician /Medical Examiner

Division of Vital Records. P.O. Box page 2 should be saly filled in by the funeral director,

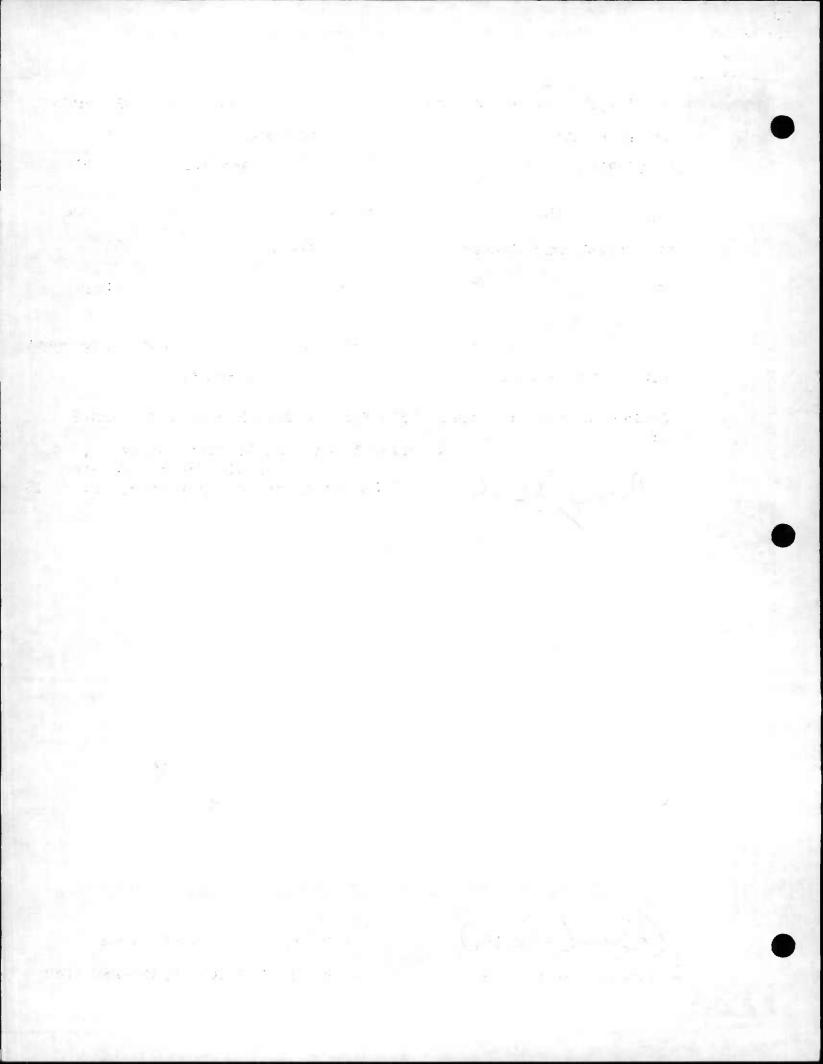
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	Hospit	Funera
	To the Hospital or Attending Physician: The law requires that the death ce	To the Funeral Director: After this certificate has been signed by the att
	1	

12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) yrs Painter Home Improvement 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Be Elijah Broughton Sr. Julia Ann Green 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 7736 Harmans Road Hanover, Md. 21076
of Disposition (Name of Date 20c. Location - City or Town, Stete Durleen L. Gunn (Sister) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State VA National Cem Aug 01,1998 Beaufort, SC. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Caple Funeral Service 21. Signature of Funeral Service Lice 5502 Winner Avenue Baltimore, Md. 21215 pilications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, one cause on each line. Enter the disease or heart failure. Approximata Interval Between Onset and Death Immediate Cause (Final disaese or condition resulting in death) ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Physician/Medical that initiated events resulting in death) Lest Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? RENAL FAILURE; HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was en eutopsy 1 Yes 1 □ Yas 2 □ No 25. Was case referred to medical BB 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) TV Yes 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 X Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Sign 29d. Data signed (Month, Dev. Year) nd title of certific 29c. License number JULY 27, 1998 O.C.M.E. ss of person who completed cause of death (Item 23e) (Type, Print) NO AKON 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura

This Davidson-Randell

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#26 @er PHYG761 7/31/98 EW Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Yaar **Physician** Brunson 1998 iold Juli /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, give streat and number) **Examiner** Pa (H-Mo-Y)
If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) Bostya 260 8 5. Social Sacurity Number Baltimor If Undar 1 Yaar 9. Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days 1□M 20 F 577-34-8895 Usuai Rasidance of Decedant Vrs Director the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits meyonement in trem 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinat must be notified at 2008. Baltimore 1 Yas 2 No NA Director 10g. Citizan of What Country? 10a. Sfreet and Number 10f. Zip Coda with 21207 25. A. Bowers Avenue Funeral Pagas 1 and 2 should be filed within 72 hours after death 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Dacedant Evar in U,S Armad Forcas? Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify Specify: 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Mary land Hospital al Hygiana. Elemantary/Secondary (0-12) Coilega (1-4or 5+) Laborer Laundry 12th grade NA 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be h and Mantal F york udson ပ 1erson 4 venia 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2/207 19a. Informant's Name/Ralationship (Type, Print) Sister 3712 Bowers Department of Health a Daltimure, mil 20c. Location - Cily or Town, Stele Irginia Avenue 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata 7-18-98 Memoral 4 □ Donation 5 □ Othar (Spacify) 22. 21. Signatura of Funaral Sarvice Licansee Nama and Addrass of Facility 30 Watask a 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Inlarval Batwaan Onsat and Daath **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical 5009:5 Examiner Dua to (or as a consaquanca of): Physician/Medical Examiner The law requires that the death certificate be asscuted bunal-transi Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Lesf and Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Dua to (or as a consequence of) usa as tha attanding for usa as ed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Diabety Mellitus by 24b. Wara autopsy findings availabla prior to complation of causa of daath? Completed 24a. Was an autopsy peen Chronic Pancipalities cartificata has 2UNO 1 Tas 2 No 1 Yas tha funeral diractor, Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home State Home 6 Klother (Specify) Domiciliary 1 Yas 2 No Hospital: 2 1 Inpatiant 2 ER/Outpalient 3 DOA After this Data of Injury (Month, Day Year) 28b. Tima of Injury To the Hospital or Attending Physikin 24 hours after death.

To the Funeral Director: After it complately filled in by the funeral 27. Manner of Death 28d. Describe how Injury occurred Certification: 28c. Injury at Work? Naturai 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Sulcida 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 ☐ Homicida 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a, Cartifian Medicai 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifier mila

Baltimore, Md

State Registrar JUL 31

31. Data filad (Month, Day, Yaar)

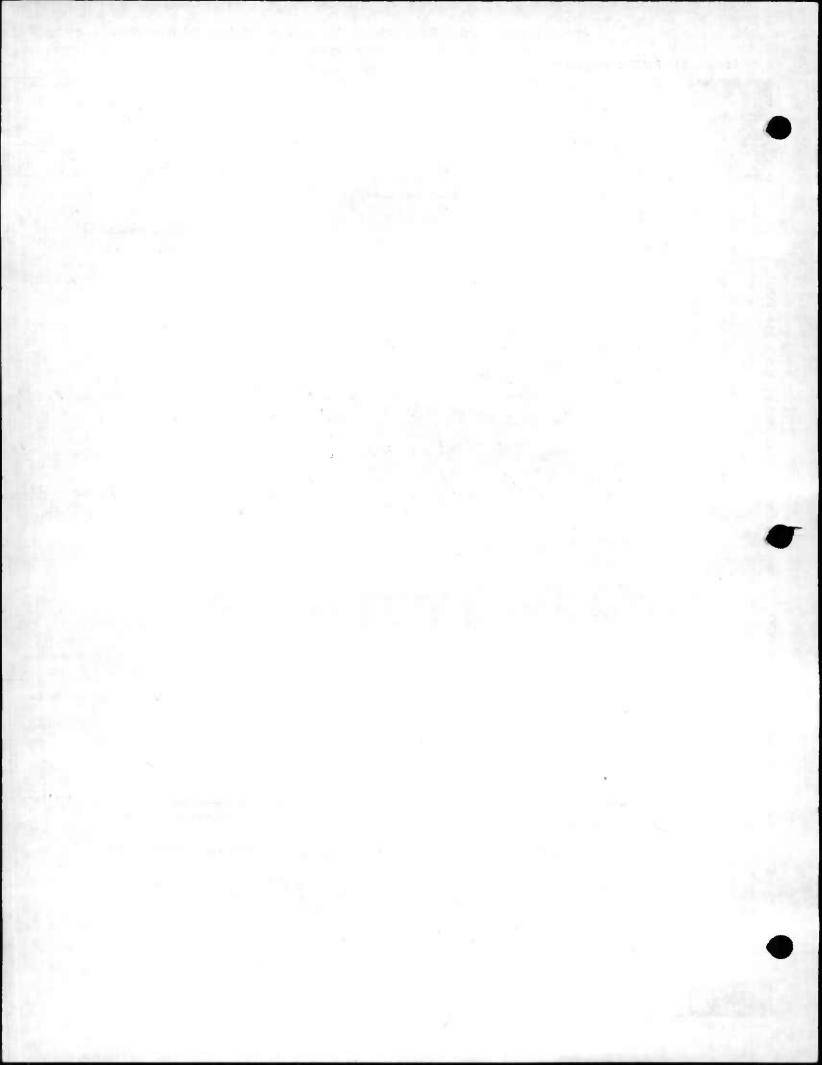
30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

1998

Belvedere

32. Registar's Signature

Suna Davidson-Randest



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#26 per Phy G761 7/31/98 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Year Month BROWN **Physician** MARV ALICE 27 1998 JULY 4:55 AM /Medical 4a Facility Name (* not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MEDICAL CENTER 7 And In vrs last birthday) If Under 1 Year BALTIMORE TOWSON If Under 24 Hrs. BALTIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) JULY 12, 19 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 20 F Months Deys Hours 218-22-3085 923 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside Çity Limits 28a-f show ortant: If itam 27 is marked other than "natural", or items 23s or 28s-f shov injury or other traumstic event, the Medical Examinal must be notlined at 1 Yes 2 No Director BALTIMORE MARILLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 07 TVENUE Funeral 12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No Specify: BLACK Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pagas 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ne any injury or other traumatic event, in a page. Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE CARR-LOWERY GLASS CO. ACKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EONARD MARV LOUGLASS ELIZABETH 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) BARBARA BATTES (DAUGHTER) 2614 GWYNNDALE AVE, BALTIHOPE, MD. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 98 ARBUTUS, MARYLAND 5 ☐ Other (Specify) CEMETERY 4 Donation of Funeral Servica Lige 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 22. Name and Address of Facility BROWN JR. FUNERAL HOME, PA Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last attanding physician and for usa as the burial-trar Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 Yes 212 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24a. Was en eutopsy has been The law page 1 Yes 2 No 2 No certificata 1 Yes 25. Was case referred to medical examiner? director Be 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home → Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 1 PInpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. Division of Vital or Attending Physician:

SPUN

death. after death in by the To the Hospital of within 24 hours a To the Funeral Completally filled in

3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and pleca, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier

29b. Signature and the of certifie

29c. License number

29d. Date signed (Month, Dey, Year)

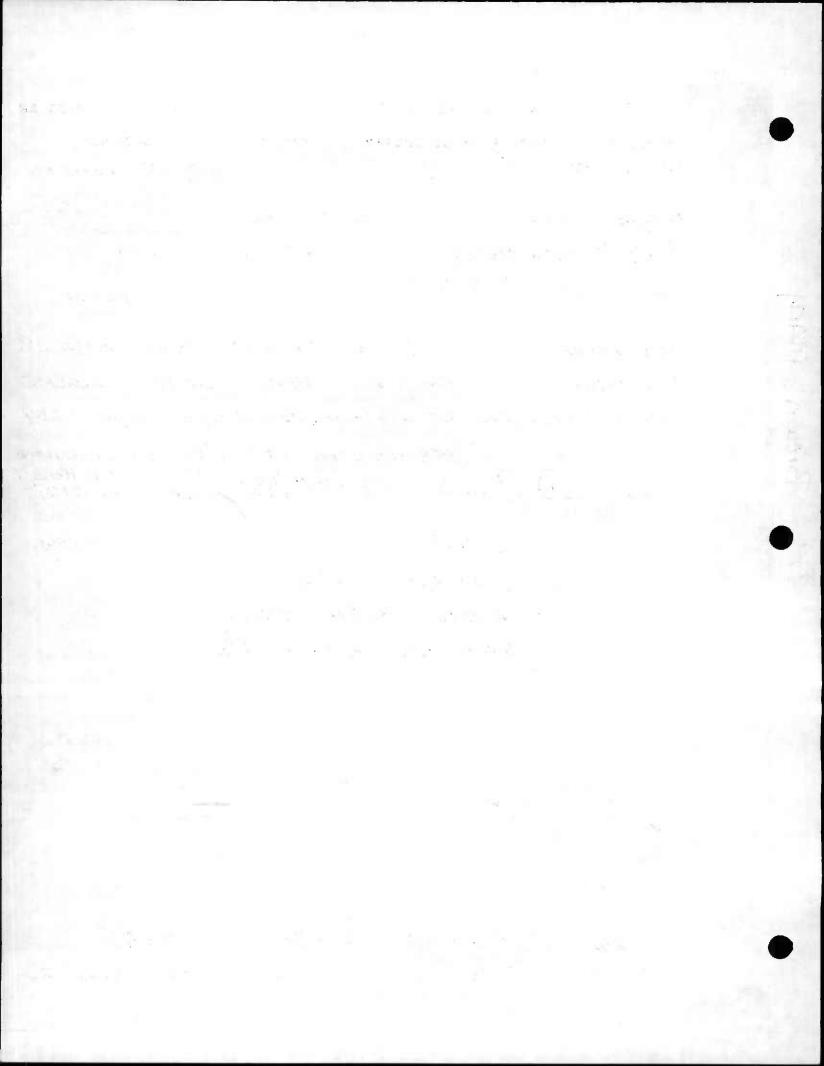
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAUID SHARE 31. Date filed (Month, Day, Year) 32. Registrates Signature

Guna Davidson 515 FAIR ment Ace, Threen, M. J.

State Registrar

edicai



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** DEADENTO /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Bon Secours Hospital Baltimore Hours Min. 8. Date of Birth (Month, Dey, Yeer)
JAN. 14, 19 If Under 1 Year 9. Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Deys Months 1941 214-38-0557 57 Vrs Maryland Director Usuel Residence of Decedent with the Maryland 10e Stete 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experient must be notified at Md. 1 ¥ Yes 2 □ No N/A Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1909 W. Lombard St. 21223 USA Funeral death 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Rece - American Indien. Bleck, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item page in high page 1.0 mental covert, the marked other than any Injury or other traumatic event, the page 1.0 mental pag 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Civil Servant 12 Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Charles E. Beadenkopf, Sr. Dorothea L. Herold 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Gloria J. Beadenkopf - sister 1905 W. Lombard St., Balto., Md. 21223 20b. Placa of Disposition (Neme of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 7/31/98 1 N Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md.

The boundary of the death. Do not enter the mode of dying, such es cardiac or respiretory errest, and the death. 23e. Pert1. Enter the disease of shock, or heart failure. 12 21075 **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner consequence of) Due to (or es a Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68780 Due to (or es e consequence of): The law requires that the death ingnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. Part II. Other 38b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 → Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause Completed 24e. Wes en eutopsy page 2 s 1 DYes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: director Be 25. Was case referred to medice 26. Piece of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 ☐ Yes 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral c 28c. injury et Work? 27. Menner of Death Certification: 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturei death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide a Funeral Di Funeral Di Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end manner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier

State Registrar 30. Name and address,

31. Dete filed (Ma

Elmo Gaydso,

/4D

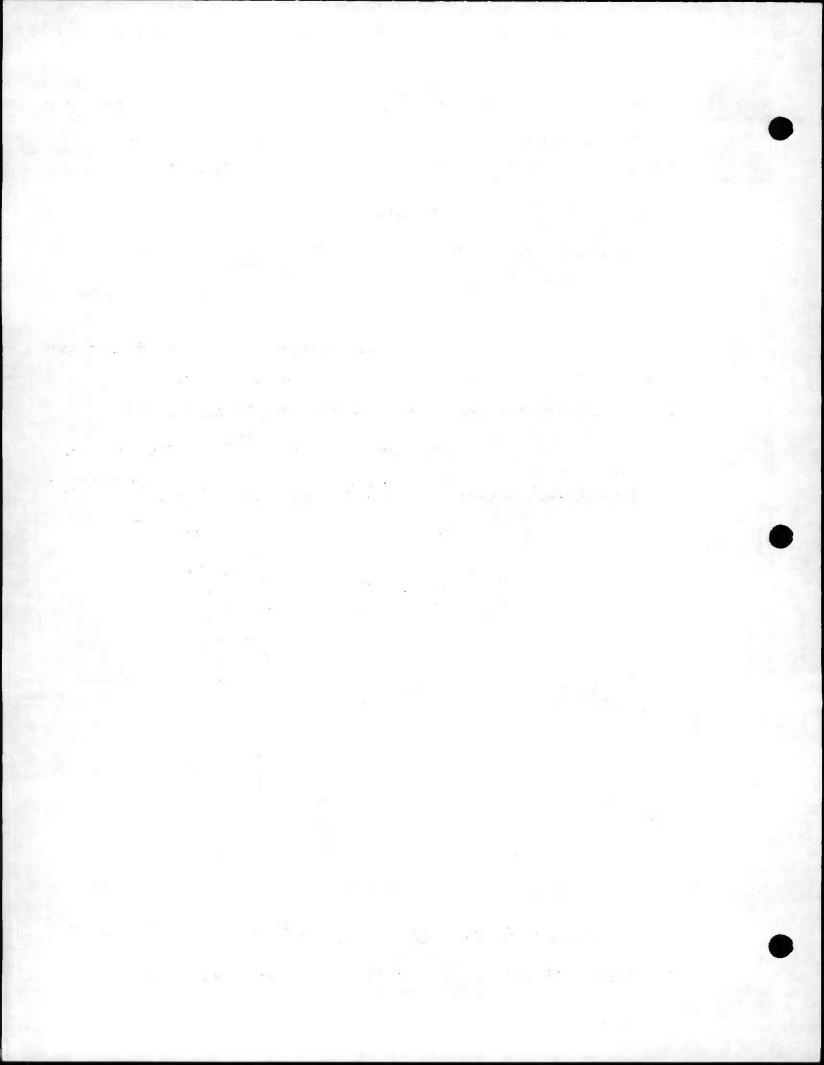
of person who completed cause of deeth (item 23e) (Type, Print)

ulia Davidson

32. Registr

5411 Old Frederick Rd., St. 8, Balto., Md.

21229



Baltimore, Maryland 21215-0020

	Plea										II Coples			ible.		
		S	tate o	f Maryla		•			lealth a <i>Death</i>	nd N	Mental Hy	rgiene Reg. No	70	3 2	33	342
1. Decedent's Name	e (First, Middl	e, Last)									2. Date of De Month	eath De	ev	Year		me of Deeth
Zei	ter Man	rie B	ransc	n							July	2		1998	2:	05am
4a Facility Name (fi	if not institution	n, give stree	et end nur	m <i>ber</i>)				1	4b. City, Tov	vn, or Lo	ocation of Deetl	h 40	. County	y of Death		
Sinai Hos		of Ba	ıltim	ore					Baltin							
5. Social Security Number 6. Sex 1 M 2 LXF 7. Age (In yrs. le						est birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.					8. Dete of Bir (Month, De Octobe	8. Dete of Birth (Month, Day, Yeer) October18,1935 Ma				tete or Foreign and
Usual Residence of 10e. Stete				100 (Town (er Loos	tion							1	nd Inei	de City Limits
Maryland						y, Town or Location odlawn										Yes 25 No
10e. Street and Nun	mber						10f. Zip (Code				10g. C	itizen of	What Cour	ntry?	
3427 V	argas (Circle	e: Ar	ot. 2-F	3		21	1244			United States					
11. Marital Status		12. \	Wes Dece	edent Ever In							pecify Yes or No	ce - Americ	American Indian,			
1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates:				2 XNo ve						Specify:			Black, White, etc. Specify: Black			
**	15. Deceden				16e. D	ecede	nt's Usual	l Occur	pation			16b. l	Kind of E	Business/In		
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					(Give kind of work done during most of working life. DO NOT use retired) Data Processing Supervi										
17. Father's Name (Last)			Dat	.a _	LUCC	:30-			ne (First, Middle				C 02.	TACTOT
The state of the s	s Stepl										arie Gl					
19a. Informent's Na Stephen:				ıghter				•			ral Route Numb pt.3-A;					4
20a. Method of Disp 1 Burial 2 Donation	☐ Cremetion		oval from	State	Place of Dicemetery,	creme	etory or of	ther plea		7,	Date / 29/98			- City or To		
21. Signature of Fu	unerel Service	1.1	هـ	Ru	٥.						ring By Randall					
23a. P vt1. P ter the	the disease, or art failure. List	complication	ons that c	aused the dis	th. Do not	enter	the mode	a of dyir	ng, such es	cardiac	or respiratory a	arrest,			Intervi	ximate al Between and Death
Immediate Cause (disease or condition resulting In death)	on	a. I	neum	noperit Due to	oneum		ence of):									
		Δ1	hdomi	inal ab	2222											
Sequentially list cor	anditions.	P. D.	Juoma		(or es a cor	nseque	ance of):			-						
if any leading to im	mmediate	1	n1 (
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resulting in death) l	Last			D00 (0)	,01 83 8 00	ISOGGG	noo oiy.									
		d									- 1					
Dari II Other eignif	firent conditi	contrib	uting to d	-ath hut not ri	thing in t	he und	taching of	auso di	on in Dart I		23h Dir	tohaco	2 1150 01	ontribute t	n the ce	ouse of death?
Part II. Other signif									9h m raiti.				2□ No			4 Unknow
Peripheral Vascular Disease											performed?			Vere eutopsy findings vailable prior to ompletion of ceuse f deeth?		
											10	Yes 2	2XNo		Yes	2 No
25. Was case refer	red to medica	ıi	26. Place of Death (Check only one)													
examiner?	No	Hosp	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp											ther (Speci	ty)	
27. Manner of Death 1 Netural 2 Accident	th 5 Pendir investi	ng	28a. Dete		28b. Tim	ne of		8c. Injur	iry et ork?] Yes 2 1	Na	28d. Describe	how inj	ury occu	irred		

Physician /Medical Examiner

Physician /Medical

Examiner

Funeral

Director

pernit. Pages 1 end 2 should be filled within 72 hours efter death with the Marylend Department of Health and Mantel Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Mostral Examinet must be notified at once.

3 Suicide

4 Homicide

31. Date filed (Morif) Day Year) 1998

Director

To Be Completed by Funeral

Physician/Medical Examiner ettending physican for usa as the burn Be Completed by Medical Certification: To

Division of Vital Records, P.O. Box 68760. To the Mospital or Attending Physician: Tha law requires that the deeth certificeta be within 24 bours after death.

To the Chronisal Director: After this cartificate has been signed by the ettending physical completely filled in by the funeral director, page 2 should be detached for usa as tha burning the completely filled in by the funeral director, page 2 should be detached for usa as tha burning.

State Registrar

1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and till of contills

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Year)

AS2402321-KB-9171

July 28, 1998

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and midrast of person who completed ceuse of death (item 23a) (Type, Print)

Kathryn G. Barnard, MD Sinai Hospital of Baltimore

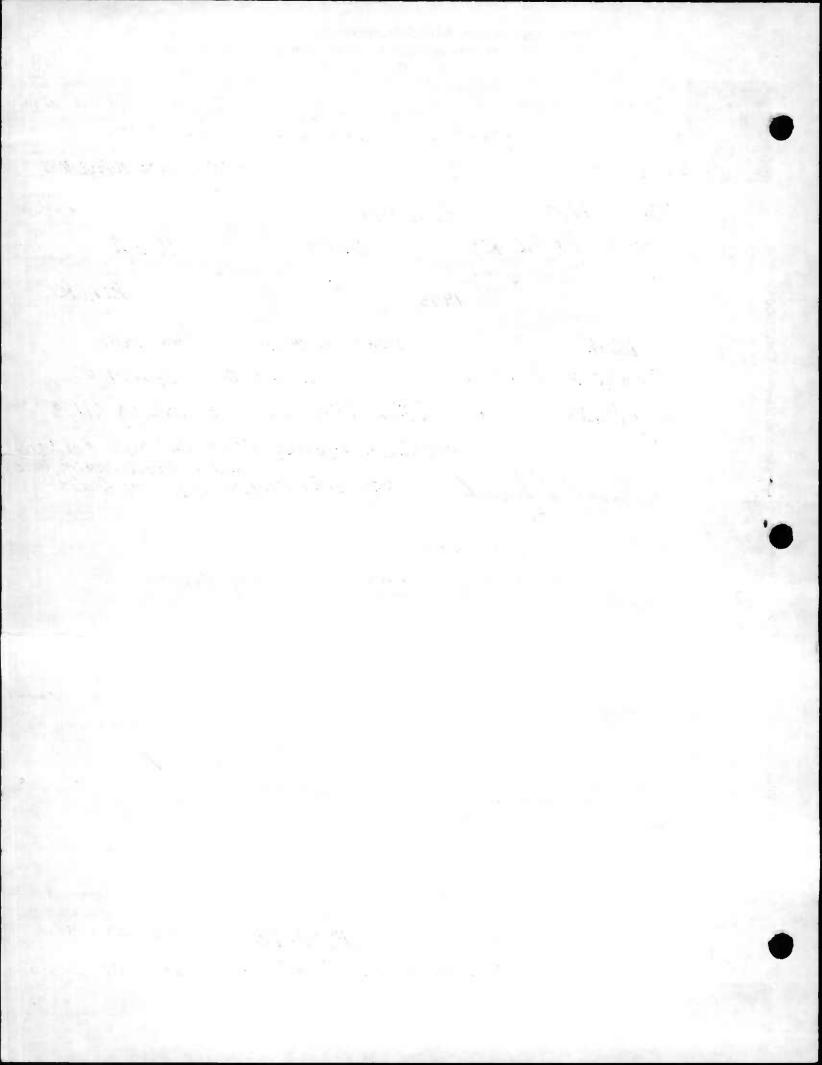
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Piease Type or Print in Black Indelibie ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Olato of It	iar y rair a	Certifica	te of De	eath	Re	g. No.		23343
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	t and 2 should Health end Mer Iom 27 Is merke	1	19a. Informant's Name/Ralationship EMILY BURTON-	Sister	, and Bio	19b. Mailing Address 3922 ce of Disposition (A	Tivert	Number or Rural F	Balti	mure, 11	20 8	2/133
Baltimore	20 1	2	20a. Method of Disposition 1		long r	of Disposition (A	pane place)	ery 8/	3/98 8	30c. Location -	Re,	MCRH/CAD
Balti	pemit. Pag Department Important: I eny injury o obce.		21. Signature of Funaral Sarvice Lice		1	22. Nama	and Addrass of	of Facility GA	RY P.	MARCI 16. M	r Ful	neent Hume
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	in 24 hour he Funer pletaly fill	alca.	29a. Certifier (Check only one) 1	hyaician: To the best minar: On the basis and mannar s	of axamination	edga, daath occurre on and/or Invastigeti	ed at tha time, on, In my opini	data end place, and lon, daath occurred	d dua to tha ca et the time, de	use(s) end me ete and placa, a	nner as s ind dua t	teted. o tha causa(s)
	To the Hospital or After within 24 hours after de To the Funeral Directo completaly filled in by the Mactical Certific		29b. Signatura and titla of certifiar	ATTO THE PROPERTY OF		- 2	9c. Licansa n	umbar		d. Data signed		
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Registrar



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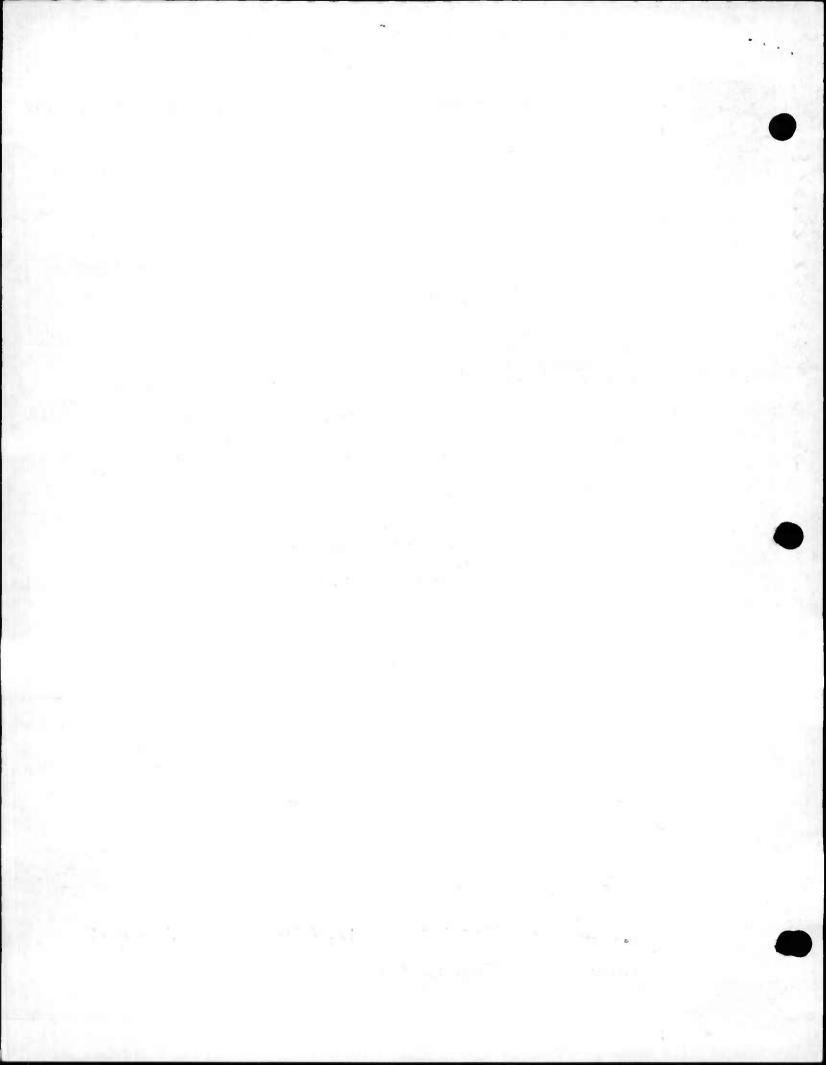
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ist, or items 23a or 28a-f show Examiner must be notified at by Funeral Director		 Marital Status Never Man Widowed 	ried 2 Merried	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	No		cedent of Hispenic Or pecify Cuben, Mexica 2 No Specify		res of No- n, etc.)			etc.
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State of Maryland / Department of Health and Mental Hygiene

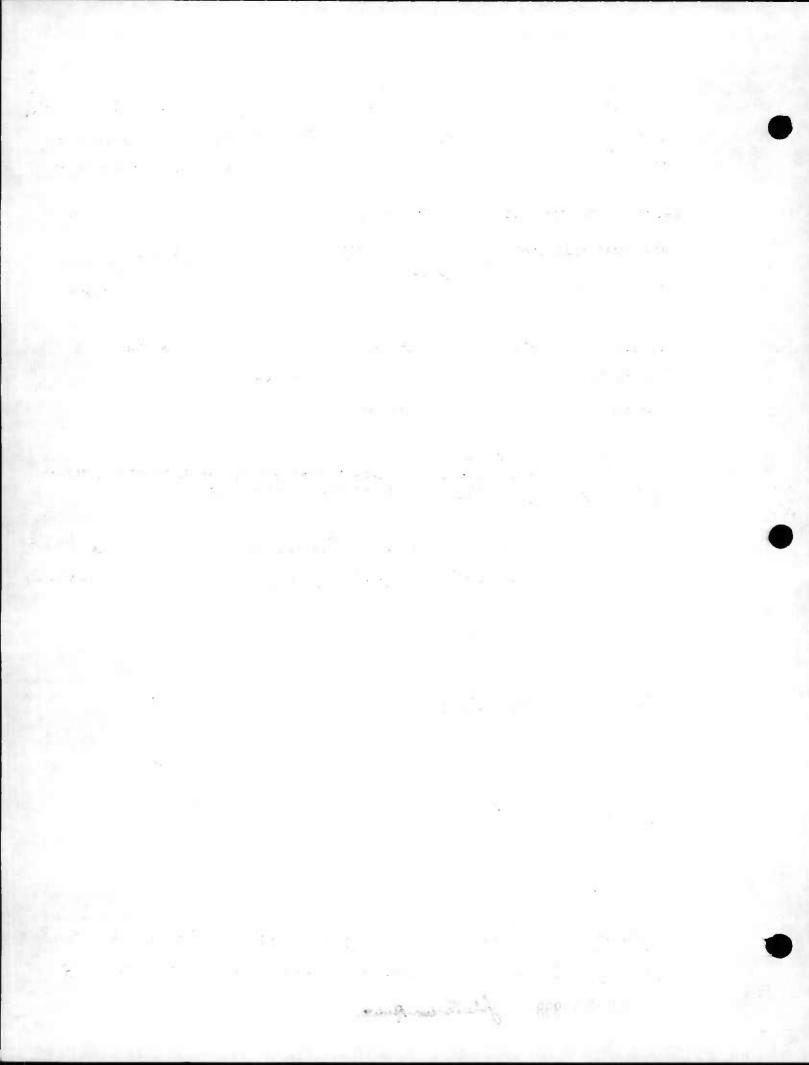
				otato or marytana, p	Certificate of	Death	Re	g. No.	0 23345
			1. Decedent's Neme (First, Middle, La	st)			2. Date of Death		3. Time of Death
	Physici /Medi		John Jero	ome Burns			July 2	24 19	98 6:50 AM
	Exami		4e. Facility Name (If not institution, give	a street end number)		4b. City, Town, or Loc	cation of Deeth	4c. County of	Death
			Vak CREST	Care Center		Parkville		Dalt	emore
?	Funeral Director		5. Social Security Number 6. S	MA OFF	ndey) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 1917 1	Birthplece (Steta or Foreign Country)
	pu		Usuel Residence of Decedent 10a. State 10b. County	10c. City. Town	or Location				10d Incide City Limite
	sho	5	Manday Balli	MANA COM	t (A) /				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number	YURE LAR	10f. Zip Code		10	g. Citizen of Wh	
	and 2 should be filed within 72 hours after death with the Maryland sellh and Mental Hygiene. n 27 is marked other than "naturel", or items 23e or 28e-f show her traumatic event, the Medical Examerer must be notified at		8824 Walth	R Blvd #3306	21	234		USA	
	ar da	Funerai	11. Maritel Status	12. Was Decedent Ever in U,S. Armed Forces?	 Wes Decedent of If Yas, specify Cubi 	Hispenic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)		American Indien, White, etc.
21215-0020	or or or or or or or or or or or or or o	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: W. W. II	1□Yes 2□No	Specify:		Specify:	white
0	2 hor		15. Decedent's E	ducation 16a.	Decedent's Usual Occup	pation	1	6b. Kind of Busi	ness/Industry
215	e. Bn "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	dunng most of workird)	19	IS ALL	Stoms Soevice
	or th	S	124RS	(agent		0	1.3. 00	HOMO DIEVICE
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∑ Za	Men Men arke	ို	William F. K	DULIS		Eva	1. Dai	(Chel)R
Maryland	l 2 sh and is m		19e. Informent's Neme/Relationship (Type, Print) 19b.	Mailing Address (Street	end Number or Rure	Route Number,	City or Town, St	ete, Zip Code)
	1 and Health Im 27		20a. Method of Disposition	IRNS WITE 886	Disposition (Name of	e Blud 733	102 Car	rey M	aryland 21234
Baltimore,	pernit. Pagas 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any fujury or other traumatic event, the Means.		1 Burial 2 Cremetion 3	Removal from Stata cemetary	, cremetory or other ple	(0)	11425 2	Uc. Location - Ci	ity or Town, State
늘	it. Partrant		4 Donation 5 Other (Specif	evans t	uneral Chapel-	BULLE	1998 F	BERST M	ul, Maryland
Ba	Departiment in poor		21. Signature of Funerel Service Licar	1) //	22. Name end Addre	ess of Fecility	US FU	upal CI	rapel
			ARDYA V	. Wells	18800 Har	Herd Rd.	Baltim	Del May	eviland 21234
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plicetions thet caused the deeth. Do no one cause on each line.	ot enter tha moda of dyir	ng, such as cardiac o	r respiretory erre	st,	Approximete Intervel Between
	Physician /Medical		Immediate Cause (Finel			0	•		Onset end Deeth
7	Examiner		disease or condition resulting in death)	e. My o car	dial In	tarctu	~		
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	that the daath cer ed by tha attendir detached for usa	Physician/	Pert II. Other elgoificant conditions of	ontributing to death but not resulting in	the underlying cause air	ven in Pert I	23h Did toh	ecco uea contr	ibute to the cause of death?
P.O.	the de	hys	Torn. Other digninoant conductors c	orthodring to death but not resulting in	are underlying cause gr	ven in Felt I.			Probably 4 HUNKNOWN
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æ	The Ita ha	E O					1 ☐ Yes	2 1 No	1 Yes 2 No
ita		Bec	25. Was case referred to medical			26. Place of Deeth	(Check only one)	
>	ystcl lls ce direc	To	axaminer? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	petient 3 DOA Oth	ner: 4 Nursing Hon	na 5 Rasider	ice 6 Other	(Specify)
0	ding Ph h. After th funeral		27. Manner of Deeth 1 Matural 5 ☐ Pending	28e. Dete of Injury (Month, Day Year) 28b. Ti	me of 28c. Injur	ry et 2	8d. Describe how	v Injury occurred	
0.00	andlr parth. pr: Af he fu	atic	2 Accident investigation			Yes 2 □ No			
Division of	r Atter de l'recte	Certification:	3 ☐ Sulcide 6 ☐ Could not b 4 ☐ Homicide detarmined	28e. Plece of Injury - At home, fam building, etc. (Specify)	m, straat, factory, office	2	8f. Location (Str. City or Town,	aat end Number Stete)	or Rurel Route Number,
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Med	one) 29b. Signeture and title of certifiar	end menner stated.	29c. Licens				Month, Dey, Year)
	F ¥ P O		255. Signistrupation title of certalar	(Juno my	DI	7040	29	7/2	1/90
	6)	/	24	70		11-	1 8
	5/		30. Name engeddress of person who	completed cause of death (Item 23a) (1	ype, Print)	4 Carel	Capol	nulo	
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	Sta	• 0	31. Date filed (Month, Day, Year)	32 Panistrill's Sianature 10	-1000-	r choi	Curr C	MUCH	



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Physician	1. Decedent's Name (First, Middle, Las	11 (1	Certifica ARK			2. Date of De Month	Reg. No.	Yeer 3. T	ime of Death
/Medical Examiner	4e Facility Name (If not institution, give		-1111	4	b. City, Town, or Lo	cation of Deeth	h 4c. County	70	AM
Xammer	13 besty Medi	cal Center			BALTIA	LORP	Ba1t	imore C	itv
neral ector	5. Sociel Security Number 6. S 414-62-3814	ex 7. Age (In yrs. 54	last birthday) If Und Month	ler 1 Year s Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct.	th ay, Year) 30, 1943	9. Birthplace (S	State or Foreign
	Usual Residence of Decedent 10e. Stete 10b. County	10c. City	y, Town or Location					10d. Ins	side City Limits
tor	Maryland Baltimo	re City	Baltimore					1 5	Yes 2□No
Olrec	10e. Street and Number		10f. 2	Zip Code			10g. Citizen of V	Vhat Country?	
ie i	4601 Pall Mall F	load		1215			U.S.A.		
by Funeral Director	11. Merital Status 1 A Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? unkn 1 Yes 2 No If Yes, Give Year or Dates:		edent of H becify Cube 2 12 No	lispenic Origin? (Sp en, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	a - American Ind k, White, etc. :: Blacl	
To Be Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) unknown	ucation de completed) College (1-4or 5+) unknown	16e. Decedent's Us (Give kind of life. DO NOT unknown	sual Occup vork done o use retired	ation during most of work d)	ing		usiness/Industry	
ပိ	17. Fether's Name (First, Middle, Last)	ulikilowii	unknown		18. Mother's Name	e (First, Middle	unknowi , Maiden Suman		
0	Edward Clark				unknown				
	19a. Informant's Name/Reletionship (1 unknown	ype, Print)	19b. Meiling Addre unknown	ess (Street	end Number or Rur	al Route Numb	er, City or Town,	State, Zip Code)
ury or othe	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion Specify	Removal from State	Place of Disposition (Nemetery, crematory of	leme of r other plea	ce)	Date	20c. Location -	City or Town, St	ate
any inj	Sanature of Fundral Service Licentification Scientification	Wade Directo			ss of Fecility Comy Board Maryland		W. Balti	more St	reet
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Comp						10	Yes 2X No	1 ☐ Yes	20 No
To Be	25. Was case referred to medical exeminer?			Lau	26. Place of Deet	h (Check only	one)		
= -	1 Yes 2 No		ER/Outpatient 3		4 LI Nursing Ho		idenca 6 Oth		
ion ion	27. Manger of Deeth 1 Neturel 5 Pending 21 Accident investigation 3 Suicide 6 Could not be	1	28b. Time of Injury M		yat k? Yes 2 □ No		how injury occur		
completely filled in by the	4 Homicide determined	building, etc. (Specif)	y)			City or To	(Street end Numb wn, State)		e Number,
completely filled in by the	29a. Certifier (Check only one)	ysician: To the best of my know inner: On the basis of examiner and manner stated.	wledge, death occurre tion and/or Investigeti	ed at the tin	ne, date and place, pinion, death occur	end due to the red at the time,	cause(s) and ma date and placa,	anner as stated. and due to lhe c	euse(s)
Nos	29b. Signature and little of cartifier	. Kein er		9c. Licens	7 0 3 1	4	29d. Date signe	d (Month, Day, 1	7 9 8
State	30. Name end eddress of person who of the state of the st	completed cause of death (Item 4 - MD - 2 600 32. Registrar's Signa	Liberty	Ho	eight. B	SALTIN	LORA.	21211	5

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #12,15,16a,b,c,18,20a,b,c,21,22 Per FH Film G762 8-7 Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Daath Day Month Yaar 30 COSB WAYNE **Physician** 25 1998 Duch /Medical 46. City, Town, or Location of Death 4a Facility Nama (If not institution, give streat and number) 4c. County of Death **Examiner** shest Center BALTIMORE Medical Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 M 2 □ F 45 220-04-1195 Yrs. Aug. 25, 1952 Maryland Director Usual Rasidence of Decedant death with the Menyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ¥ Yas 2 □ No Maryland Director Baltimore City Baltimore 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2701 Orlean Street 21224 U.S.A. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacedant Evar In U.S. Armed Forcas? unknown permit. Pages 1 and 2 should be filed within 72 hours efter Depentment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any finury or other traumatic event, the Mental Earthine. 1 ☐ Yas 2/12 Mo If Yas, Giva Year or Datas: 1 Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) unknown Tour Bus unknown 12 unknown Driver unknown 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be unknown Melvin Cosby Mary Ann Taylor 20 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Melvin Cosby/father unknown 20b. Placa of Disposition (Name of commatary, cramatory or other place)
Metro Crematory, Inc. Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 8/4/98 Baltimore, Md. 4 Donation 5 Other (Speat) in state Rong a Som Ware Edwird A. Gregorchik State Anatomy Board to 05 Society Of Maryland Ince 229 Frederick Rd. Baltimore, Maryland 21201 21228 nons that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** ERMINAL CARCINOMA of Lung /Medical immadiata Causa (Final Bru wy diseasa or condition rasulting in death) Examiner teral CARCINOTUA 4 Owan The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last pue physician s the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown by 24b. Wara autopsy findings available prior to been si 24a. Was an autopsy Completed complation of causa of death? hes ie 2 2 No 1 Yes 1 ☐ Yas 2 No certificate or Attending Physician: 25. Was casa ratarred to madical axaminar? director Be 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No To 1 Unpatient 2 ER/Outpatient 3 DOA this After this funerel of 27. Mannar of Death 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 1 Watural 5 Panding Invastigation efter death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) à 4 Homicida filled in 24 hours e Hospital Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifian pletely (Check only one) within 2

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State Registrar

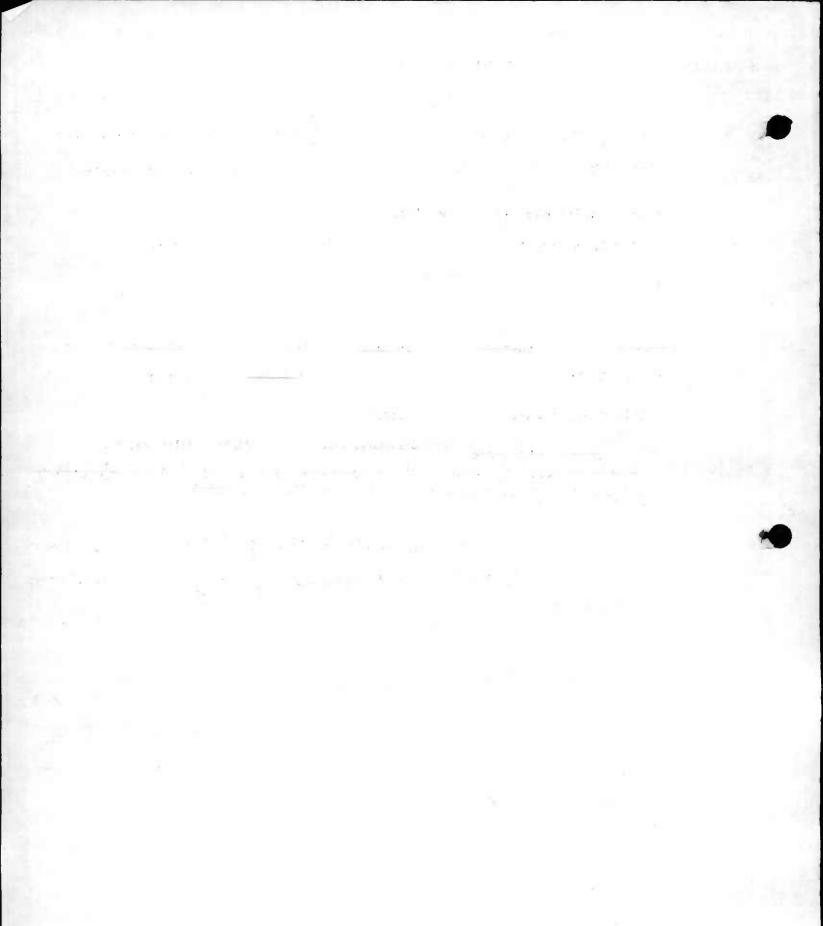
29b. Signatura and titla of certifie

WANGT

30 Nama and addrass of person who complated cause of death (Itam 23a) (Typa, Print) 2600 L Spent 32. Registrar's Signature

29c. License number

29d. Data signad (Month, Day, Yaar)



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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#20b per FH G761 7/31/98 EW 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth : 40 P.M **Physician** ohn 6 · /Medical Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deg Examiner Medical Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours 22014222 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, the Medical Examinat must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltmere Baltimore NOWes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 515 Clemer Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Raca - American indian, Black, White, etc. 11 Marital Status 1 Never Merried 2 Married 1□ Yes 20 No Specify: Caulas 1 AN Specify P 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Ma. Be Inknown 2 Inknown 19a. Informant's Name/Relationship (Type, Print) (Details 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2/20 / Greene Baltimore Mar 20c. Location - City or Town Seannette Cannor rk /) N. Greer 20b. Place of Disposition (Name of cometery, crematory or other place) Street Marshard Date 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Owings Mills Mary land tores SOR 21. Signa of Funeral Servica Licansee rVIN Baltimone Maryland Approximate Intervel Between Onset end Death 1712 W. Wor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart feilure. List only one ceuse on each line. Physician /Medical SEPSIS Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical the Due to (or as a consequenca of): # 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the d be detach 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed ils centificate has t i directin, page 2 r 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) OS PITTL 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. injury at Work? 28d. Describe how Injury occurred Certification: 27. Manner of Death 28b. Time of 5 Pending investigation 1-2 Natural 1 Tyes 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Division of Vital Records, P.O. Box 68760, or Attending after deat Director: hours 34

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altimore, Maryland 21215-0020

State

Medical

29a. Certifier

(Check only one)

Registrar

31. Date filed (Month, Day, Yeer)

29b. Signature and the of certifier

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me MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

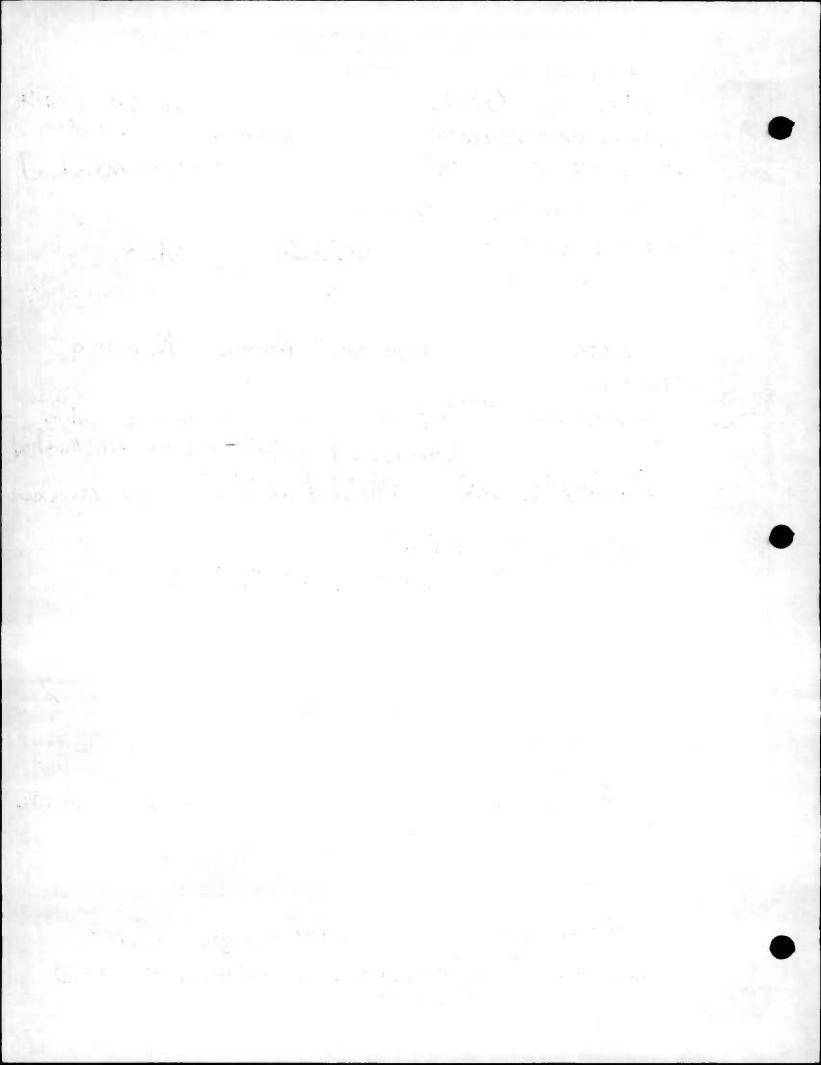
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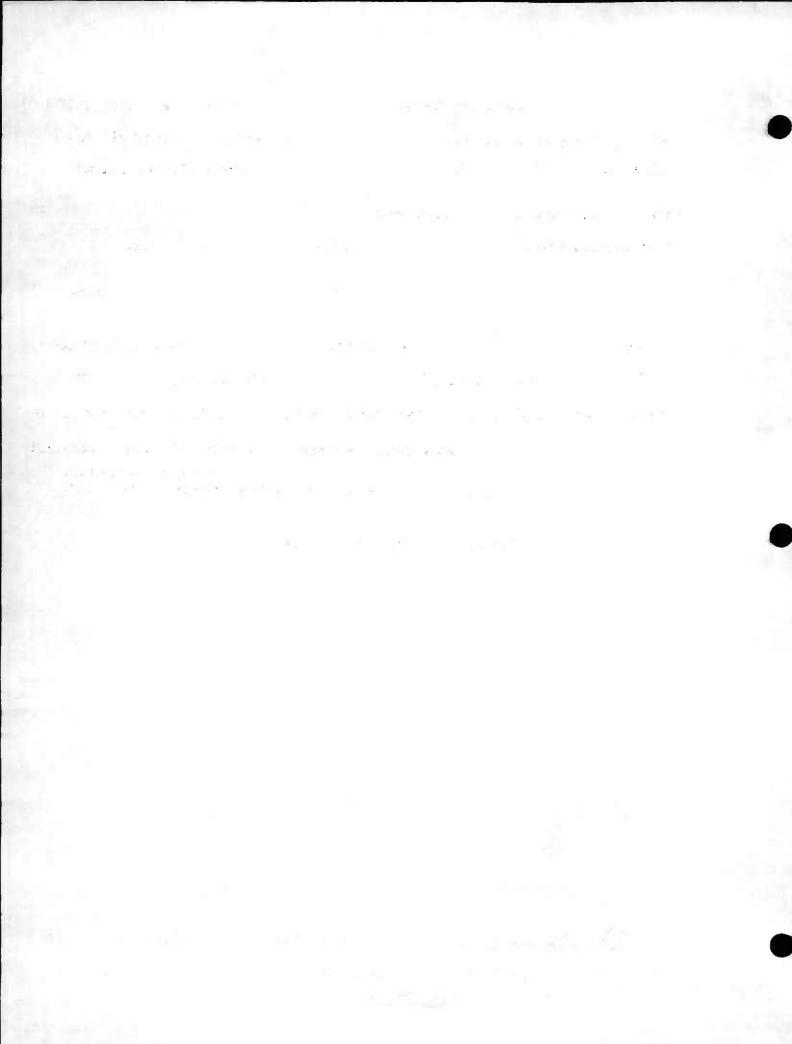
29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 29, Paul Francisco Churchin, Sr. 1998 July 1:15 PM 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth Annapolis Anne Arundel Anne Arundel Medical Center 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. NOV 26, 1946 9. Birthplece (State or Foreign 5. Social Security Number 10 M 20 F California 366-46-5983 Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Stevensville Queen Annes 10f. Zip Code 10e Street end Number 10g. Citizen of What Country? 21666 USA 1018 Lovepoint Road 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Automotive Elementary/Secondery (0-12) 12 College (1-4or 5+) Mechanic Repair 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Abraham Churchin Aurora Pagliucoli 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zlp Code) 7921 Donegal Lane Springfield, VA 22153 Dennis Churchin/Brother 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 07/30/98 Baltimore, MD Metro Crematory, Inc. 21. Signature Runeral Ser 22. Name end Address of Fecility Cremation Society of MD, Inc. Luca Gregorchik 299 Frederick Road MD 21228 Edward Baltimore. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) DISEMSE 006KIM Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No. 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) 1□ Yes 20 No Hospital: 1 ☐Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

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Certification:

edical

27. Manner of Death

1 Naturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature and 1896 of

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygione. Important: if Item 27 is marked other than "natural; or Items 23a or 28s-f show any Injury or other fraumatic event, the Modical Examinat man to notified any injury or other fraumatic event, the Modical Examinat man to notified any injury or other fraumatic event, the Modical Examinat man to notified any injury or other fraumatic event, the Modical Examinat man to not the man of the Modical Examination of t

Baltimore, Maryland 21215-0020

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Records,

Division of Vital

After death. after death

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State Registrar 900 61713 20

Day, Year)

31

5 Pending investigation

6 Could not be determined

HNN mois

1 🖒 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner es steted.

28c. Injury et Work?

29c. License number

1 Yes 2 No

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

be of person who completed cause of deeth (Item 23e) (Type, Print)

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature Julia Davidson Gandalle

28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

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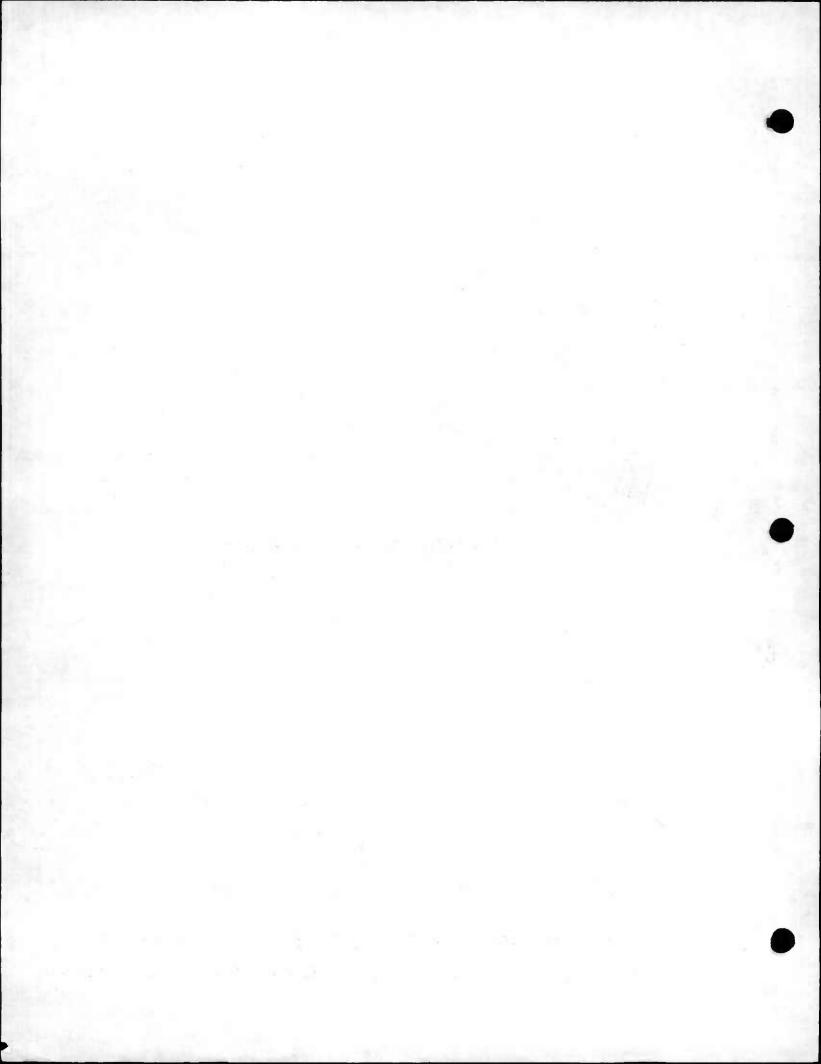
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert E. July 28, 1998 Curtiss 7:20 AM /Medical 4e Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 633 Eliot Road Pasadena Anne Arundel 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 69 Yrs. Days Hours 218-24-6337 Director Aug. 13, 1928 Washington, DC Usual Rasidenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, in Medical Expriner must be notified a page. 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 633 Eliot Road 21122 Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 [∄/Yes 2 □ No If Yes, Give 1953 – 55 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantery/Secondary (0-12) College (1-4or 5+) 4 Purchasing Agent Flectronics 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leon Francis Curtiss Chloe James 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Marcella A. Curtiss - Wife 633 Eliot Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremelion 3 ☐ Removel Irom Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Metro Crematory, Inc. July 31 Baltimore, Maryland 21. Signature of Funerel Service Licansee 22. Name and Address of Facility Stallings Funeral Home, Inc. 3111 Mountain Road, Pasadena, Maryland 21122 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only proceed the cause on each tine. Approximata Intervat Batween Onsat end Death **Physician** of Prostate Immediala Ceuse (Finat diseesa or condition rasulting in deeth) /Medical Cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner cate be asscuted for use as the bunel-tran Sequentially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Diseese or injury end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician that initieted events rasulting in death) Lest Due to (or es e consequence of): The lew requires that the death 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. sate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings evelleble prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: director, 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Tesidence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Panding Investigation deeth. 1 Yes 2 No e Hospital or Attendi 24 hours after deeth e Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at tha time, data and placa, end due to the cause(s) end menner steted. 29a. Certifier completely (Check only one) To the To the To the I 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) man 30. Name and addrass of person who completed causa of deeth (Item 23a) (Type, Print) Glas Burnis 5. Crain ovman mo

State Registrar

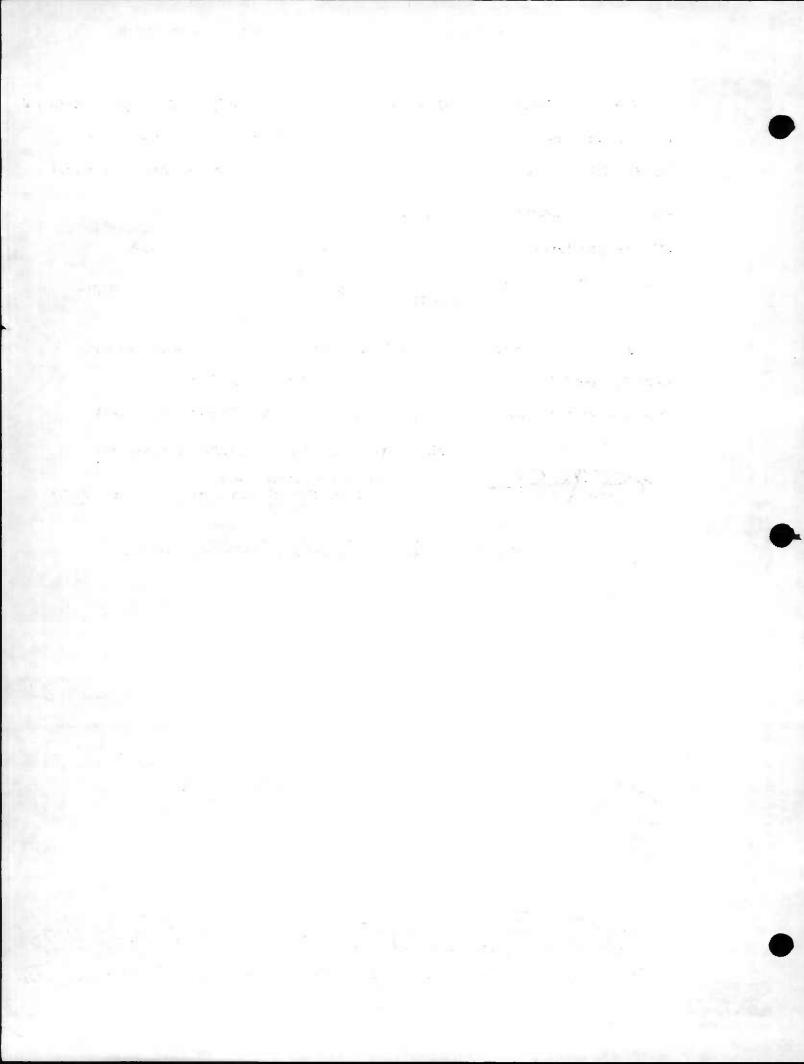
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32. Figistrar's Signature



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	State of Maryland / Department of Healt Item: 5 per F.H.G0762 8/7/98 reb Certificate of Dea		/glene Reg. No. 98 23352
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/Medical Examiner		y, Town, or Location of Deat	
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Director	218-22-8818 1 A 2 F 69 Yrs. Months Days Hou	ours Min. (Month, D. July	
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permit. Pa Departmen Important: eny Injury once.	22. Nama and Addrass of F Lemmon Fund		
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10+1	30. Name and addrass of person who complated educa of death (Itam 23a) (Type, Print)		1-1/2 1tmml
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State Registrar	JUL 31 1998 Julie Davidson Fandace		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 9:30 P.M 1998 4b. City, Town, or Location of Deeth Chester 27 Annette Lawrence Margaret /Medical 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BAITIMORE CenTen Kosean hirthday) If Under 1 Year If Under 24 Hrs. Navs Hours Min. Rosedale FRANKLIN SQUARE HOSPITAL CEN 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👿 F 213-26-3662 88 June 1, 1910 Director Maryland Usuel Residenca of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Parkville. 10g. Citizen of What Country? 10e. Street end Number 7 is marked other than "natural", or items 23a or treumatic event, the Magical Examiner must be a 21234 USA 8810 Walther Blvd. Funeral Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien. Bieck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Dental. n/a Bookkeeper 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be end Mentel I Lawrence Johanna Fiege Aloysius 19a. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) James Lawrence Redifer/Son 2108 Woodfork Road, Timonium, Maryland 21093 20b. Piece of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Department of H Important: If ther any injury or other 1 ■ Buriai 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/98 Baltimore, Maryland New Cathedral Cemetery 21. Signature of Funeral Service Licenses (a) 22. Name end Address of Facility Lemmon Funeral Home Bryan W. Clary 10 W. Padonia Road, Timonium, MD 23e. Part1. Enter the dialese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or have failure. List only one cause in each light. Approximete tntervei Between Onset and Death **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical a. RespiraTory Failure
Due to (or es a consequence of): 1 Hour Examiner Physician/Medical Examiner CongesTivE HEAR Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): o CORONALY AR ICR Due to (gres e consequence of): ARTERY Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attanding Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1 Yes 2NNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Natural Hospital or Attanding 124 hours after death.
 Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physicten: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

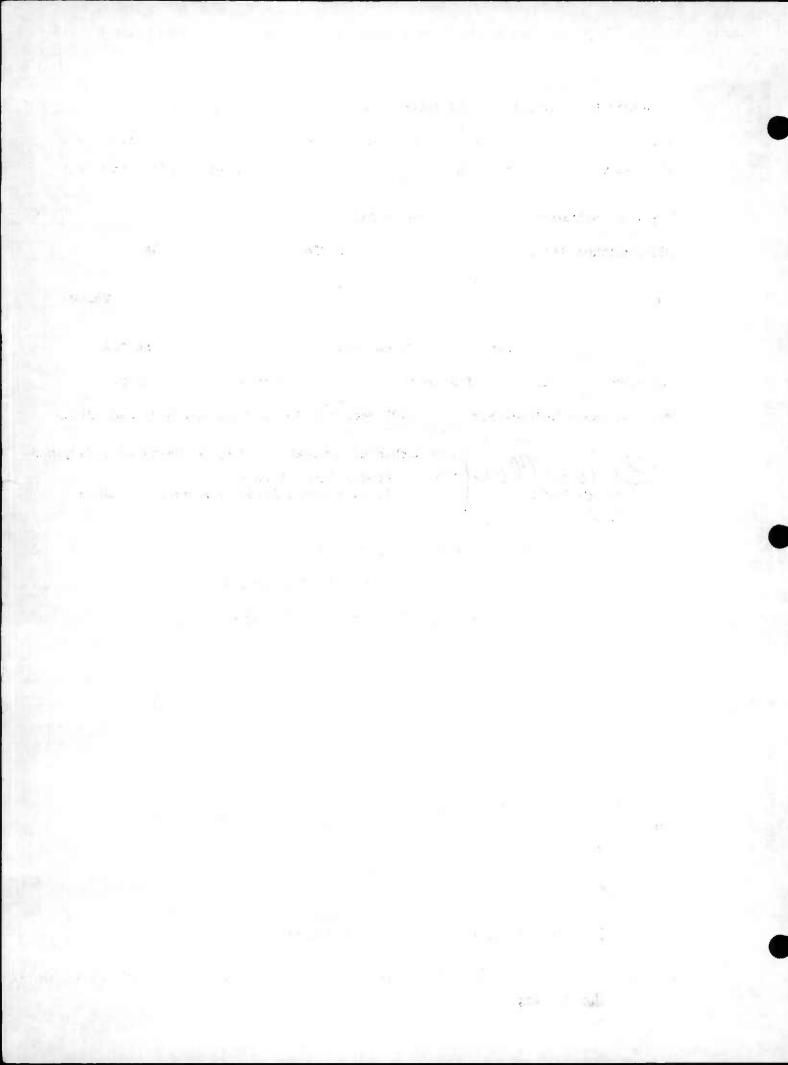
Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. To the Hospi within 24 hou To the Fune completely fi 29a, Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier s, MD. D26116 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10 Square DR. BAITIMORE, MARY LAND 21237 9000 FRANKlin 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Julia Savidson Randale

DHMH 16 Rev 6/95

Registrar

Division of Vital

MARGARET



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				State of	of Marylan		artment of I rtificate of		nd Mental H	ygiene (it	23354
	Physici		1. Decedent's Name (First, Middle		LADV				2. Dete of D	Death Day	Year	3. Time of Death
N	/Medi		ELIZABETH 4a. Facility Nama (If not Institution		CADY Imbar)			4b. City, Town	JULI n, or Location of Dec			2:00AM
	Examir Funeral Director	ier	6612 Seward Ro 5. Social Sacurity Number 578-26-4828		7. Aga (In yrs. 73	last birthday) Yrs.	If Undar 1 Yaar Months Days	Bo	owie	Pri	nce G	eorges leca (Stete or Foreign try) ware
	yland how		Usual Residence of Decedent 10a. State 10b. County Md Prine	ce George	10c. Cit	y, Town or Lo	ocation				10	0d. inside City Limits
	with the Mar 3a or 28a-f s	Funeral Director	10e. Street and Number 6612 Seward Rd				10f. Zip Code	20715		10g. Citizen of V USA	What Coun	1☑ Yes 2☐ No stry?
020	be filed within 72 hours efter deeth with the Maryland tiel Hyglene. d other than "natural", or flems 23a or 28a-f show event, the Medical Examinst must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed F	2₩ No ive		Was Decedent of I if Yas, specify Cub 1 ☐ Yas 2 ☐ No	dispanic Originan, Mexican, F	n? (Specify Yas or Puerto Rican, etc.)	No- 14. Rac Blac Specify	e - Americ ck, White, o	
Baltimore, Maryland 21215-0020	within 72 ho	Completed	15. Decedent (Specify only highes Elemantary/Secondary (0-12)	s Education t grada complated) Collega (dent's Usual Occup kind of work done DO NOT use retire		f working	16b. Kind of Bu		
9	Hygie ther ther		12. 17. Father's Name (First, Middle, I	.ast)		<u>l</u>	Iomemaker		Name (First, Midd		wn ho	me
/lan	2 should be filed withir end Mentel Hygiene. Is marked other than raumatic event, the Mentel than the Mentel than the Mentel than Mentel t	To Be	VERNON M	cCAULEY				,	MARGARET			
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re,	ss 1 and of Health Item 27 other tr		20a. Method of Disposition			lece of Dispo	osition (Neme of metory or other ple		Date Date	20c. Location	City or To	wn, State
timo	. Pege tment of mint: If		Burial 2 Cremation 4 Donetion 5 Other (Sp	ecify)	State	timore	Nationa	1 Cem.	July 27,			.11e, Md.
Bal	permit. Peges ' Depurtment of H Important: If ite any injury or of once.		21. Signature of Funeral Service L	Z Be	da	16	000 Anna	polis :	s Funeral Rd., Bowi	e, Md. 2		
c			23a. Part1. Enter the disaasa, or shock, or haart fallure. List of	complications that only ona causa of	used tha deati each line.	h. Do not ani	tar tha mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disaase or condition	RES	PIRATOR F	P) LIRE						d son
ı	Examiner	<u>.</u>	rasulting in death)	a	Due to (o	ras a consec	quance of):					
	uted d ansit	Examiner	Sequentially list conditions	b. []\Pi	Due to 10	r as a consec	anenca ot).				2	y weekg
68760,	eath certificate be axecuted ettending physician and for use es the burial-transit	edicai Exe	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last	c. CARCI	NOVED OF		Nx					5 76025
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	death le etter ed for u	Physician/M	Part II. Other significant condition	na contributing to d	eath but not resi	uiting in the u	nderlying cause gi	ven in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of death?
P.0	es that the de igned by the c be datached								10	Yes 2□No	3 ☐ Prot	pably 47 Unknown
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al R	The age	Con							10	Yes 2 No	10	Yes 2□ No
Vita	Physician: The this certificate ral director, page	Be	25. Was casa raferred to medical examinar?	Hospital:			Ott	or:	f Death (Check only			
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Division	al or Attandlr s after deeth. al Director: Af ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	ned 288. Place	of Injury - At ho ing, etc. (Specify		reet, factory, office		28f. Location City or T	(Street end Numb own, Stete)	er or Rura	l Routa Number,
7	toepit 4 hour uner	edicai	29a. Certifier (Check only one) 1 Certifying 2 Medical E	xaminer: On the b	best of my kno- asis of examinationer stated.	wiedge, death tion and/or In	n occurred at the the vestigation, in my o	me, data and popinion, death	place, and due to the occurred at the time	e cause(s) and ma a, data and place,	inner as st and due to	ated. the causa(s)
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			30. Name and address of person v	DIVISION OF	Hemotous	2 /DNG	Print) LOCA GEORGE	row Un	HURSET MAK	11 CENTES L	Vashing	TON, D.C.
	Sta Registr		31. Date filed (Month, Day, Year)	32. F	egistrer's Signa	tura Hang	2002			•		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 22,1998 /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deet/ **Examiner** If Under 24 Hrs. If Under 1 Year 8. Date of Birth Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 M 2□ F Devs 3-04 Months Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If New 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, if a Medical Evantree must be notified at once. 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimor Funeral Director Maeyland 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: KORLAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) YES 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be ဥ 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end, Number or Rurel Route Number, City or Town, State, Zip Code) ONY 20b. Place of Disposition (Neme of cametery, cremetory or other place) Pete 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 Removel from State 4 Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of F⊌heral Servica Licenses vans 23a. Pert7. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying such es cardiac or respiretory errest, shock, or heert feliure. List only one cause on eech line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical 120 Examiner Due to (or es e consequence of): Physician/Medical Examiner 10 1256 Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, The law requires that the daath certificate be Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? been signed by the s should be datached 1 des 2 □ No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveileble prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? s certificate has t director, page 2 s 1 ☐ Yes 2000 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Plece of Death (Check only one) exeminer 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Mennes of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Naturel daath. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) E4 hours ofter Funeral Directions of the Funeral Direction of the Funeral Direction of the Funeral Property of the Funeral Pro Direc 4 - Homicide Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2 Dedical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner steted. 29a. Certifier edical (Check only one) To the within 2 8 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 0

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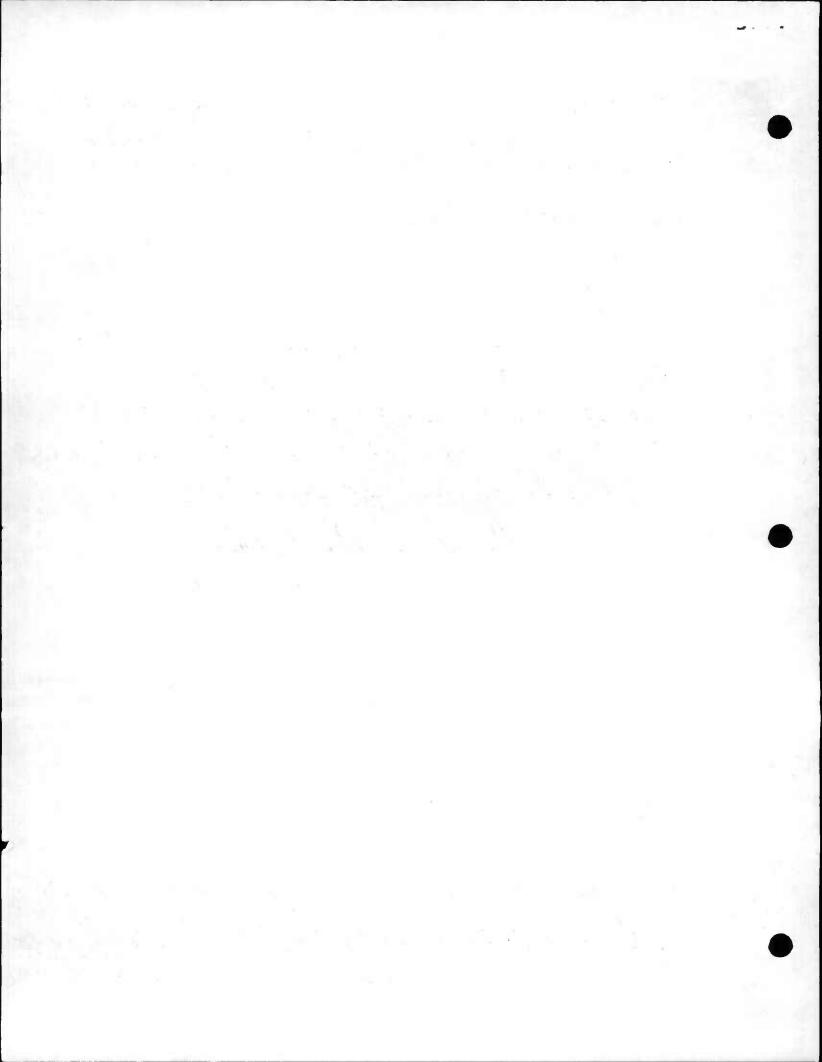
State Registrar 31. Date filed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31 1998

32 Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vest Physician 1017 78 ARLOCK 1998 ARY FLORENCE /Medical c. County of Death 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street end number) Examiner 703 BERNADITTE HARFORD FOREST DRIVE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) HILL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 □ M 25 F Yrs. 220 18 6153 Usuel Rasidenca of Decedant APRILIO 1927 Director 1 PARYL 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 25 No Director HARFORD FOREST PARYLAM 10e. Street and Number 10g. Citizen of What Country? mant be n 703 BS U.S.(4 ROAL URIVS Funeral 21020 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status permit. Pages 1 and 2 should be filed within 72 hours affact. Department of Health and Montal Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event. the institution of the page. 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Detes: 1 Never Merried 26 Merried Specify: WHITS 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 127RS. HOMENAKE 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be STROL 2 MAILLIG 220, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1127215 DRIVE FOREST HILL PARVLAND B. LARLOS 703 BIRNAUETTE 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Dete 701231 Buriel 2 ☐ Cremetion 3 Ramoval Irom State 1998 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND IMZIERY 22. Name end Address of Fecility 21. Signature of Funerel Service Line 1988 -BELAIR P.A. 21050 -LEGAHS. ZWPORT 6 RIVE FORZET 23e. Pert1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haer failura. List only one cause on each lina. **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last To the Hospital or Attending Physician: The law requiras that the daath certificata be associated within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humatinan Due to (or as a consequence of) Records, P.O. Box 68760, Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown edical Certification: To Be Completed by 24b. Wara autopsy tindings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 28 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4□ Nursing Home 5⊠ Residenca 6 □Other (Specify) Hospitel: 1 Yes 2€ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division 108 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide 28e. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicida

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2 MORTH AVE BULATR LEWZAH. 2 32. Registra's Signature.

Quina Daydoon-Randall. 31. Date filed (Month, Dey, Year) JUL 3 1 1998

155 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) end menner stated. 29c. License number

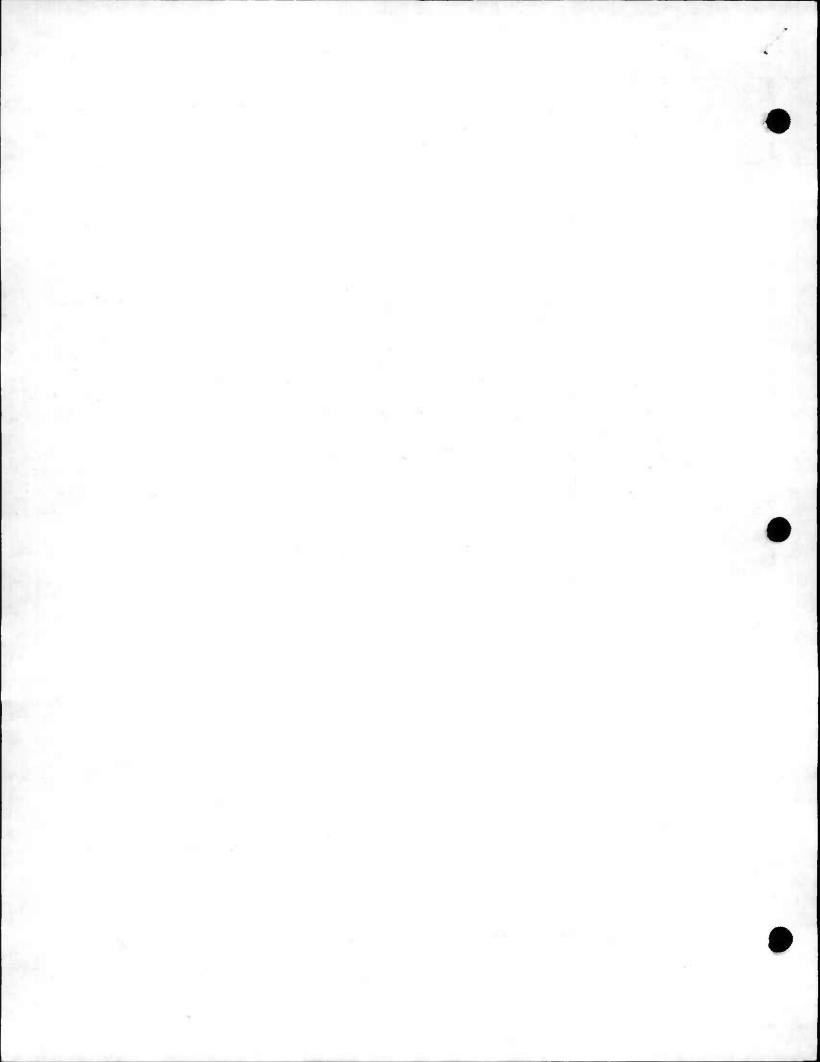
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29d. Date signed (Month, Day, Year)

Registrar

29a Cartifier

29b. Signeture end title of gertifian



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end: #10b Per	Anatomy Board Film G761	State of Maryl 7-31-98RC		artment of F rtificate of		Mental Hy	/giene 9	8 233	57
Physician (Madisol	1. Decedent's Name (First, Middle, Las Marianne Dew					2. Dete of D Month	Dev	Veer	of Death
/Medical Examiner	4e Fecility Neme (If not institution, give NORTH ARUND		ital			Location of Dee	th 4c. County		EL
Funeral Director	5. Social Security Number 220-30-2578 6. St		yrs. last birthday Yrs.	Months Deys		S. 8 Date of B	irth ley, Year) 2, 1920	9. Birthpiece (State Country) unknown	e or Foreig
deeth with the Maryland ms 23e or 28e-f show cross be notified at	Usual Residence of Decedent 10a. State	ore	City, Town or L					10d. Inside	City Limit
th with th		Road		10f. Zip Code 21061			10g. Citizen of V	Vhat Country?	
urs efter urs efter Examina by Fui		12. Wes Decedent Ever Armed Forces? un 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	in U,S. 1known	Wes Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispenic Origin? (en, Mexican, Pue Specify:	Specify Yes or N erto Rican, etc.)	Biad	e - American Indien, k, White, etc. :: White	
- s 1 3 - 5	15. Decedent's Ed (Specify only highest gra- Eiementery/Secondary (0-12) unknown	ucation de completed) College (1-4or 5+) unknown	(Give	dent's Usuel Occup e kind of work done DO NOT use retire	petion during most of w d)	rorking	16b. Kind of Bu	siness/Industry	
	17. Fethers Neme (First, Middle, Last)				18. Mother's N unknow		e, Maiden Sumam	(e)	
re, Maryland 1 and 2 should be file Health end Mental Hy Health end Mental Hy Health end sent 27 is marked othe ther traumatic event To Be (19e. Informant's Name/Reletionship (7 unknown	Type, Print)		ing Address <i>(Stree</i> i known	t and Number or Rural Route I		ber, City or Town,	Stete, Zip Code)	
Baltimore, semi. Pages 1 a permit. Pages 1 a pertinent of Her montant: If Item my Injury or other size.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify	Removel from State	Ob. Place of Disposition (Name of cemetery, crematory or other place)			Dete	20c. Location -	City or Town, State	
Caltimate Cantillary C	21. Signature of Fugural Sewice Lean BOHALC 23a. Part : Enter the disease, or comp whock, or heart tailure: List only of	alace	deeth. Do not en	altimore,	Marylan	nd 21201		Approxin	nete Between
Examiner	disease or condition resulting in deeth)	a	to (or es e conse					1	
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d by the detached	Pert II. Other significant conditions co	ontributing to death but not	t resulting in the	underlying cause gi	ven in Part I.		d tobacco use con	ntributa to the caus	
The law requires the cate has been signed in page 2 should be defined.							es en eutopsy formed?	24b. Were eutops available pri completion of deeth?	or to
VITAI MEDICIPAL: The law certificate hes rector, pege 2.	25. Wes case referred to medical exeminer?				26. Place of D	1 Ceath (Check only	Yes 20 No	1 ☐ Yes 2	!□ No
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UNISION il or Attending a after death. Director: After d in by the fune ertification	2 Accident 3 Suicide 4 Homicide		At home, farm, soecify)	treet, fectory, office		281. Location City or To	(Street and Numb own, Stete)	er or Rural Route N	lum <i>ber</i> ,
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	reiclan: To the best of my linar: On the bests of exen end manner steted.	knowiedge, dea ninetion and/or i	th occurred et the tinvestigetion, in my	me, date end pia opinion, deeth oc	ce, end due to the	e cause(s) and ma s, dete end piece,	anner as stated. end due to the caus	e(s)
To the comp	29b. Signeture and title of certifier 30. Name end eddre of person who certifier	completed cause of death	(Item 23e) (Tyne	29c. Licen: DA:	se number 3977		29d. Date signer	d (Month, Day, Year Q5 199	1
State	31. Date filed (Month, Day, Year)	301 Hospistrer's S	ity on	ve, Coler	Busen	E m	2, 2,0	61.	
Registrar	JUL 3 1 199	8 Julia De	widson B	ndelle					

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State of Maryland / Department of Health and Mental Hygiene

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Elizabeth E. Eirolf Familior Famil				1. Decedant's Nama (First, Middla, La	st)										Vana	3. Tim	a of Death
## Facility Name First Institution Country				Elizabeth	E.		Eino	olf				July 2	6.		Year	8:0	0 A.M.
Procedure Control Co	4			4a Facility Nama (If not institution, give	a street and num	iber)				4b. City, Tov	wn, or Lo	-	-		f Death		
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To see the control of		With Man		1304 Hillsway Cou	rt			212	24				1	ΔΡΙ			
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Physician // Reproximate principles of the first in disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interest allare. List only one cause or a ach fina. Part Court Cour	Ball	Depertition in the service of the se		21. Signature of Funaral Sarvica Lica	nsae		J	John C	. M	iller,	Inc					010	25
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30. Name and address of person who completed causal of death (Item 23a) (Type, Print) Towsm Md 2120C		g Ph er th heral			28a. Data o	f Injury		of 2	28c. Inju	iry at		28d. Dascribe	how In	jury occurre	ed		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month FARCAS July 22 4b. City, Town, or Location of Death 1998 2:36 P.M 4a Facility Name (If not institution, giva street and number) 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) Months MOXM 2□ F Yrs. May 10, 1913 Rumania 10c. City, Town or Location 10d, fnside City Limits ¥XYes 2□No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 1111 University Blvd., West, Apt. 515 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bieck, White, etc. 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2☐xNo Specity: Specify: White 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Auto Mechanic Auto Industry 18. Mothar's Name (First, Middla, Maiden Sumama) Matilda Kolb

15. Decedent's Education (Specify only highest grada completed) Eiementary/Secondary (0-12) 12 Yrs

17. Father's Name (First, Middle, Last)

Solomon Farcas 19b Malling Address (Street and Number or Rural Route Number, City or Town, Stele Zip Code) 4200 Massachusetts Avenue, N.W., Apt. 405 19a. Informant's Name/Relationship (Type, Print)

Peter Farcas, Son Washington, D.C. 20016

20b. Place of Disposition (Neme of cemetery, crematory or other place)

July 23, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

Mount Lebanon Cemetery Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

neger 23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onsat and Death

tmmediate Cause (Final disease or condition resulting in death) Atherosdertic Cardiovasular Discene Due to (or as a consequence of):

1040015

Sequentielty list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

ASPIRATION PNEUMONIA

GASTRU INTESTIMAL BILASOING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown

24e. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 20 No

1 ☐ Yes 2 ☐ No

e referred to medical	26. Place of Death (Check only one
7	

Hospital: 1 ☐ Inpatient 2 □ ER/Outpatient 3 □ DOA | Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No

28c. Injury et Work? 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the causa(s) and menner steted.

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ayithtie of certified

ass of person who completed cause of death (Item 23e) (Type, Print) 30. Name and add FERRARA OR WHEATON MO 20906 3941 RAYMOND BASS

Now fulia Davidson State 1998 Registrar **DHMH 16 Rev 6/95**

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at page. Baltimore, Maryland 21215-0020

> Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

with the Marylend

MIHAI

5. Social Security Number

Usual Residence of Decedent

3 ☐ Widowed 4 ☐ Divorced

10b. County

579-64-1965

10e. Street and Number

10a. State

Directo

Funeral

þ

Completed

Be

10

Physician/Medical Examiner

by

Completed

8

Certification: To

edicai

25. Was cas

Maryland

The law requires that the death certificete be and been signed by t should be detach is certificate has

Division of Vital Records, P.O. Box 68760, or Attanding Physician: funeral death. after death Director: A d in by the f hin 24 hours after the Funeral Dire npletely filled in t Hospital within 2 To the I 0

Carried and Author PROPERTY IN COMPANY AND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	E.	J	3	0	U

Inc.

	Physician	Decedent's Name (First, Middle, Last)									3. Time of Death	
	1 and 2 should be filed within 72 hours efter death with the Maryland Health and Mental Hygiena. Health and Mental Hygiena. To Be Completed by Funeral Director	Hugh Smith Fosque							JULY		1998	03.30 11
		4e Facility Name (If not Institution, give street and number)				4b. City, Town, or Lo			ocation of Dee	th 4c. County	4c. County of Deeth	
		12126 LONG RIDGE LANE					BOWIE PRINCE GEORGE					EORGES
		5. Social Security Number 230–34–6753	67	67 Yrs. Months Day			s Hours Min. (Month, I			Birth 9. Birthplace (State or Foreign Country) 15, 1930 Virginia		
		Usual Residence of Decedent										
		10a. State 10b. County	10c. City, Town	10c. City, Town or Location						1	0d. Inside City Limits	
		Maryland Prince	Вот	Bowie							★ Yes 2 No	
		10e. Street and Number 10f. Zip C								10g. Citizen of Whet Country?		
		12126 Longridge Lane				20	20715			United States		
0		11. Marital Status 1 Never Married 2 Married	ever In U,S. 13. Was Decedent of If Yes, specify Ci					ecify Yes or N Rican, etc.)		14. Raca - American Indian, Black, White, etc.		
020		3 ₹ Widowed 4 □ Divorced	If Yes, Give Year or Dates: 51-54		1 ☐ Yes 2 ☐ No Specify:					Specif	Specify: White	
15-0		15. Decedent's E (Specify only highest g	16a. D	16a. Decadent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)				ing 16b. Kind of Business/Industry				
212		Elementary/Secondary (0-12)	5+)	Electrical Engineer					Federal Government			
D		17. Father's Name (First, Middle, Las	DIE				18. Mother's Name (First, Middle					
ylan		Albert Fosque Annie Lewis										
Mar		19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							Code)			
~		Victoria Daul/daughter 426 Ridge Rd. #5 Greenbelt, MD 20770										
Baltimore, Maryland 21215-0020		20a. Method of Disposition ★★Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec	cametery	20b. Pleca of Disposition (Neme of cametery, crematory or other place) July 29. Fairview Lawn Cemetery				, 1998 20c. Location - City or Town, State Onancock Virginia				
Balt	permit. Pegas Department of Important: If I any Injury or once.	21. Signature of Funesal Service Winsee 22. Name and Address of Fecility Robert E. Evans Funeral Home Inc. 16000 Annapolis Rd. Bowie, MD 20715										
	2h.usisism	23a. Part1. Enter the disease, of cor shock, or heart failure. List onl	nplications that caused y one ceuse on each li	the ceath. Do no							, in	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	1120-00	-10 111	0-11-01-0	201	MA	10 D	a policy)	MSCHIAD	06	TEA
	Examiner	disease or condition resulting in death)	a.HYPERTE	Due to (or as a co		SCL	EKU	CU	RKNION	ASCULACE	275	EVI
	je le			Due to (or as a co	insequenca or).							
1.878	certificate be executed ding physician and use as the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of):										
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876	tha b											
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Bo	ath tee											
o.	the d	Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pa					en in Part		23b. Did tobecco use contribute to the cause of death?			
О.	E 80	CANCER OF PROSTATE						10	Yes 2□ No	3 ☐ Pro	bably Unknown	
Records, P.O. Box 68760,	bou hou									is an autopsy dormed?	av	ere eutopsy findings allable prior to impletion of cause death?
Re	he law la hes bage 2 s								10	Yes 200		Oeath r □Yes 2□ No

Division of Vital

State Registrar

Be

Medical Certification: To

25. Was case referred to medical examiner?

29b. Signature and title of certifier

Hospital:

5 Pending Investigation

6 Could not be determined

GOL

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

examiner?

27. Menner of Deeth

1 Natural Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) end manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

3 DOA

29d. Date signed (Month, Day, Year)

JULY 24, 1998

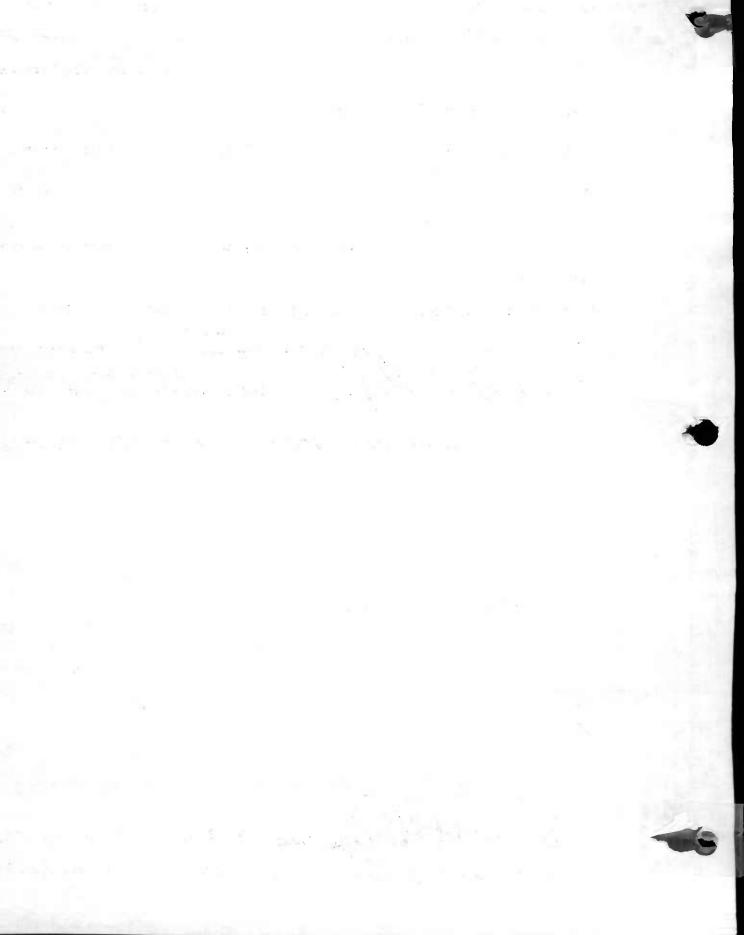
28f. Location (Street and Number or Rural Route Number, City or Town, State)

DRIVE, CHEVERLY, MARYLAND 20785 JR AND 3001 HOSPITAL

26. Place of Death (Check only one)

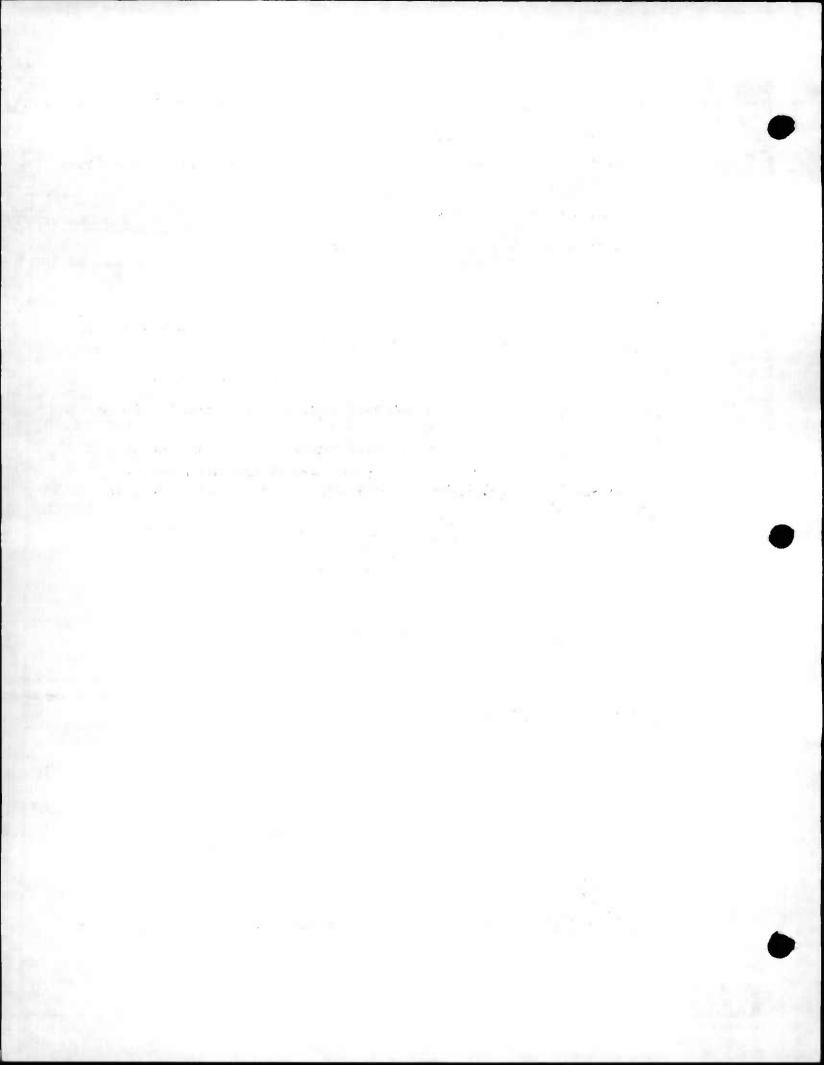
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred



State of Maryland / Department of Health and Mental Hygiene

				Cei	tifica	te of	Death			Reg. No.			001
	1. Decedent's Name (First, Middle	, Last)						2.	Date of De		Vaar	3. Tin	ne of Deeth
Physician	Margaret T	. Gress							Month July	27, Day 199	98 Yeer	11	:00 P.M
/Medical Examiner	4a Facility Name (If not Institution		mber)				4b. City, Tow				ty of Death		
LXUIIIIII							Tows	on		Bal	Ltimor	e	
uneral	5. Social Security Number 220–09–6468	6. Sex 1 □ M 2 □XF		last birthday)	If Unde	r 1 Year Days	If Under 2 Hours	Min. 8.	Date of Bir (Month, Da	th (Yeer) 191	9. Birthp	place (St	ete or Foreign
rector		ILIW ZLA	19	Yrs.					July 1	10, 191	9 New	ior	ĸ
	Usual Residence of Decedent 10a. Stete 10b. County		10c, C	ity, Town or Lo	cation						1	IOd. Insid	de City Limits
ector	MD Baltin	nore	Tow									10	Yes 2 No
funeral Director	10e. Street and Number 2300 Dulaney Va	lley Roa	d			204				10g. Citizen o	f What Cour	ntry?	
Je Je	11. Marital Status	12. Was Dec	pedent Ever in U	J,S. 13.	Was Deci	edent of h	lispanic Origi an, Mexican,	in? (Specifi	y Yes or No	- 14. R	ace - Americ		in,
þ			2 XNo		1 Yes	37		1 40110 1 110			ity: Wh:		
Completed	15. Decedent	's Education)	16a. Deced	dent's Usi	uat Occup	pation during most d)	of working		16b. Kind of	Business/In	dustry	
npie	Elementery/Secondary (0-12)		(1-4or 5+)					S. Working		Baltim			У
Co	12	0		Perso	onne]	Cle				Police		•	
Be	17. Father's Name (First, Middle, I	Last)								, Maiden Sumi	eme)		
2	Thomas Conway									Ooxzen			
er traumatic To	19a. Informant's Name/Relationsh James C. Gress									er, City or Tow		o Code)	
ands.	20a. Method of Disposition 1 Burial 2 ☐ Cremation		State	Place of Dispo	netory or	other ple			Date	20c. Location			te
Injury B.	4 Donetion 5 Other (Sp. 21. Signature of Funeral Service I		LO	rraine						Wood1		MIN.	
any	21. signature of Equipment Service I	Q Kd	Mer							ectors, Listown		21	133
	23a. Parti Enter the disease, or shoot, or heart failure. List	emplications that	caused the dea	th. Do not ent	er the mo	de of dyi	ng, such as c	cardiac or re	espiratory a	rrest,			ximate el Between
cian	Sept. or reservance. Cost	only one dapse on	each mie.						. /	- Kak		Onset	and Death
dical	Immediate Cause (Final disease or condition		Mes	11/2	my	067	ra per		7	« NON			
iner	resulting in death)	е	Due to (or as a shise	puénce of):							
ner	STATE			1/1/3	ne!	= /480	57-5						
Examiner	Sequentially list conditions,	b. —	Due to (or es e consec	quence ot):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events										i		
edicai	that initiated events resulting in death) Last	C	Due to (or as a conseq	uence of):							
ν/Mec		d	Mala a										
Physicia	Part II. Other significent condition	ns contributing to	death but not re	sulting in the u	nderlying	cause gi	ven in Pert I.						usa of death?
be datached for the by Physicial	111	1							10	Yes 2 No	3 ☐ Pro	babiy	4 Synknown
	1/1001/25	prolls fe	3 -						24a. Was	en autopsy	24b. W	/ere euto	opsy findings
. paga 2 should be d									perfo	ormed?	av	/ailable p	prior to n of cause
Comp									10	Yes 20 No	-		2 No
Ü	25. Was case referred to medical						26 Dina	of Dogst "			11	□ 162	Z LI NO
I director.	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 E	Ot Ot	hor		Check only	one)	Wher (Speci	ihr)	
	27. Manner of Death	28a, Date	of Injury	28b. Time o		28c. Inju Wo	4 LI NUI			how Injury occ		1977	
a funer	1 Natural 5 Pending	9	nth, Dey Year)	Injury	М		ork?]Yes 2∐N	No					
led in by tha funers Certification:	3 Suicide 6 Could r 4 Homlcide determ	ned 286. Plac	e of Injury - At I	nome, farm, str ify)	reet, facto	ry, office		281	I. Location (City or To	(Street and Nu wn, Stete)	m <i>ber</i> or Rur	el Route	Number,
		g Physician: To th											use to
plately fill edical	(Check only 2 Mettical I	Examiner: On the i	basis of examin nner stated.	ation and/or in	vestigatio	n, in my	opinion, deet	n occurred	et the time,	date end pled	e, end due t	to the ce	use(s)
E co	29b. Signature applitte of certifier	-5	2		2	9c. Licen	se number	26		29d. Date sig			ear)
	1 V Tene					1	1 > 1			7	28	98	
10	30. Neme and address of person	who completed cau	ise of death (Ite	m 23a) (Type,	Print)						176		
	5DD15 010	KILID	A 3.	305	31.7	5/4	129	RT	> 7	PUXTO		29	>
State	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature		X-V			c/_\)	-	
	.1111 3 4 1	13 15 1 //.	N 1	70 4									



KENNETH HOWARD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	98	2	3	3	6	6
_			_			-

11:00 AM

1 X Yes 2 No

Physician * /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Chester Howard

10XM 2□ F

2. Dete of Death Day 1998 ear YIUL 21,

4a Facility Name (If not institution, give street end number) 524 NORTH CHARLES STREET APT. #315 4b. City, Town, or Location of Death 4c. County of Death

5. Social Security Number 579-12-6873

BALTIMORE 7. Age (In yrs. lest birthday) If Under 24 Hrs. If Under 1 Year Months Days Hours

Baltimore 8. Date of Birth (Month, Dey, Year) March 1, 1 9. Birthplace (State or Foreign Country)

Funeral Director

with the Maryler

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

à

Completed

Be

2

Physician/Medical Examiner

by

Completed

Be

2

Certification:

Medicai

permit. Peges 1 end 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: if tem 27 is marked other than "natural", or the any injury or other traumatic event. If a Medical Exemptor

Physician

The law requires that the death certificate be executed

P.O. Box 68760.

Records.

Division of Vital or Attending Physician:

/Medical Examiner

physician end

use as ettending p

s been signed by the

page 2 has

director,

funerai

completely filled in by

this certificate

After

efter death.

Director: Aft

24 hours e Hospital

To the I within 2

Baltimore, Maryland 21215-0020

Usual Residence of Decedent Directo Funeral

10b. County Maryland Baltimore City

10c. City, Town or Location Baltimore

1918 Massachusetts 10d. Inside City Limits

U.S.A.

10e. Street and Number

524 North Charles Street

10f. Zip Code 21201 10g. Citizen of What Country?

12. Was Decedent Ever in U,S. Armed Forces?

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Raca - American Indian, Black, White, etc.

Transportation

1 Never Married 2 Married 3 Widowed 4 Divorced

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

1 Yes 2 No Specify:

Specify: White

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Ernest Chester Howard

18. Mother's Name (First, Middle, Maiden Sumeme) Harriet Stratton

19a. Informant's Name/Relationship (Type, Print)

Ernest W. Howard/brother

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 524 North Charles St, Baltimore, Maryland 21201

20a. Method of Disposition

20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca)

20c. Location - City or Town, State

1 ☐ Burlat 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify)

Ronald Wade, Director

22, Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Immediate Cause (Finel disease or condition resulting in death)

Alberosclerote & Cardiovascular Disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as a consequenca of):

Due to (or as a consequence of):

23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1.

ЗЬ.	Dld	tobecc	o use	con	tribute t	o the	cause	of dee	th?
	1 🗆	Yes	2 🗆 N	lo	3 Pro	bably	4 🗆	Onkne	ow.

24a. Was an autopsy anhal

24b. Were autopsy findings available prior to completion of cause of death?

1 Ves 2 □ No

1 Ves 2 No

25. Was case referred to medical XX Yes 2□ No

27. Manner of Death

1 PNatural

2 Accident

3 Suicide

28a. Date of Injury (Month, Dey Yeer) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 1 Yes 2 No

28d. Describe how Injury occurred

26. Place of Death (Check only one)

6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyalcien: To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) end menner as steted.

28f. Location (Street end Number or Rure! Route Number, City or Town, Stete)

(Check only one) 2\(\overline{\text{Medical Examiner:}}\) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Dennis J.

29c. License number O.C.M.E

29d. Date signed (Month, Dey, Year) JULY 22, 1998

Vermis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Chute no 31. Date filed (Month, Dey, Year)

JUL 3 1 1998

32. Registrar's Signature hie Davidson

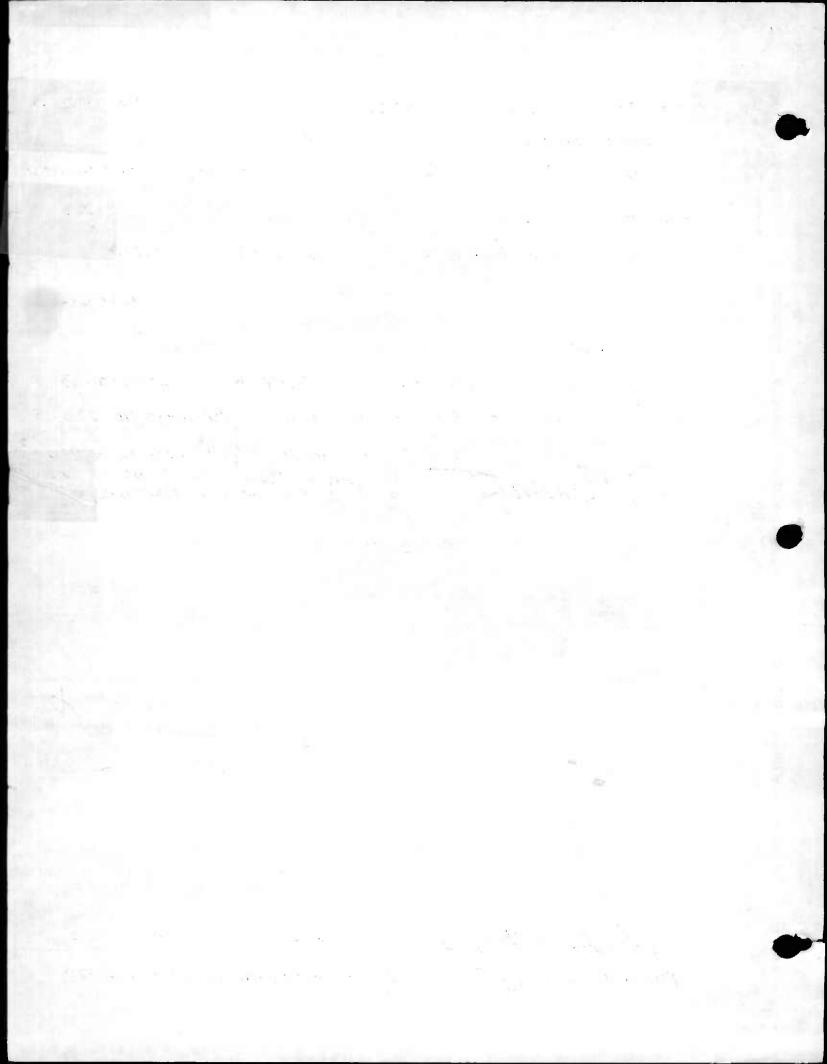
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		/ 8-5-98 WK.	Certifica	te of Death	Dec	ı. No.	_	0000
Trend. WES	PART I, 27 PER MEO G76 1. Decedent's Name (First, Middle, Las		O O T T T T T T T T T T T T T T T T T T	o or Boain	2. Date of Death			Time of Death
Physician	RANDOLPH	EUGENE	HARRIS		Month July	Day 28 19	998 1	0:22 AM
/Medical Examiner	4e Fecility Name (If not institution, give		HARRIS	4b. City, Town, or Lo		4c. County		
42	Bon Secours Hospi	tal		Baltimore		N	/A	
Funeral	5. Sociel Security Number 6. S		Months	r 1 Year if Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey, Y	(ear)	9. Birthplace (Country)	Stete or Foreign
Director	014-06-8017	ZM ZUF	6 Yrs.		OCT. 05,	1951		LANC
and and	Usual Residence of Decedent 10a. Stete 10b. County	10c. City	, Town or Location				10d. In	side City Limits
Mary Fied	MADILLAND A	110	1.	BALTIHORE	= 0, -	1	1	ÝYes 2□No
should be filed within 72 hours after death with the Maryland not Mental Hygiana. I marked other than "natural", or items 23e or 28e-1 show unatic event, the Medical Examinal must be notified at To Be Completed by Funeral Director	10e. Street and Number	671	101. Zi	p Code		. Citizen of W	Vhat Country?	
h with	1920 PENRO	SP AVENU	IE	2122	3	u	SA.	
al, or heme 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Maritel Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Dece	edent of Hispanic Orlgin? (Specify Cuben, Mexicen, Puerto	ecify Yes or No- Rican, etc.)		e - American Inc. k, White, etc.	dien,
A Pu		1 Yes 2 No	1 ☐ Yes	V/		Specify		/
"natural", or refical Exam leted by F	3 Widowed 4 Divorced	Year or Dates:	40. 0	-10		Oh Kind of Bu	BLAC	CK
	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usu (Give kind of w life. DO NOT	ork done during most of worki	ing	DD. KING OL DU	islness/Industry	
than the M	Elementary/Secondary (0-12)	College (1-4or 5+)	UNKNOWN			NKNOWN		
event, event, Be C	17. Fether's Name (First, Middle, Last)			18. Mother's Name				
To B	RAV F.	HARI	RIS	BERTH	LA M.	LIF	Scon	113
7 is marke traumatic To	19a. intorman 's Name/Relationship (7			ss (Street end Number or Rure	al Route Number,	City or Town,	Stete, Zip Code	9)
a 0 -	LUCILLE WORK	ELL (SISTER)			E. BALT	THORE,	MD. 2	1215
	20a. Method of Disposition **Disposition 3 Cremetion 3	C	ece of Disposition (Na emetery, cremetory or	other plece)	Date 20	Oc. Location	City or Town, S	State
mant of hand o	4 Donation 5 Other (Specify		T. ZION	CEMETERY Y	-4-48 1	ANSO	OWNE,	MP.
Department of Important: If it any injury or once.	21. Signature of Funeral Service Licen	500	22. Name e	and Address of Facility	WW JR	. Fun	VERAL	HOME
70 = 4 4	HADOU	MA	214	ON. FULTO		BALT	THORE !	102121
	23 Part Bhier the disease, or company or heart teilure. List only	plications that ceused the deeth one cause on each line.	. Do not enter the mo	de ot dying, such es cardiac	or respiratory arres	d,	Inter	roximete val Between
Physician							Ons	et and Death
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting In death)	DRUG USE COMPL	ICATING HYPER	RTENSIVE CARDIOVA	SCULAR DIS	EASE	-	
		Due to (o	r es e consequence of):				
in and rial-transit Examiner		b	es e consequence of	Λ,			-	
sician and burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	Due 10 (0)	es e consequence ou	,.				
physicia tha bur	that initiated events	C Due to (or	es e consequence of):				
ng physician and Las tha burial-transit	resulting in death) Last						1	
igned by the ettanding Is be datached for usa as by Physician/Me	447 177 17	d				11.0		
The lew requires that the deeth cardifule less been signed by the estanding page 2 should be datached for use as completed by Physician/Me	Part II. Other significant conditions of	ontributing to death but not resu	alting in the underlying	ceuse given in Part I.	23b. Did tob	acco uee col	ntribute to the	ceuse of death
d by datacl					1 ☐ Ye	8 2 □ No	3 Probabty	4 Wiknow
signed of be day					Ode Mes	autone	24h Wara a	utopsy findings
The lew raquir sate has been s page 2 should				Service Service	24a. Was en perform		evailable	e prior to tion of cause
hes to					05		ot death	17
					OO Ye	2 □ No	A Yes	2 □ No
s cartificate hes b director, page 2 s	25. Was case reterred to medicel examiner? 1 Xves 2 No	Hospital:		Othor	h (Check only one		(0.7.1)	
E E E	27. Manner of Death	28a. Date of Injury	ER/Outpetient 3□ D	A Nursing Ho	me 5 Resider 28d. Describe how			
ding Ph th. Aftar th funaral	1 Natural 5 Pending 2 Accident investigation	(Month, Dey Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
lal or Attending Physician: s after death. ii Director: After this cartific ed in by the funaral director. Certification: To Be (3 Suicide 6 Could not be		me, tarm, street, fecto	ry, office	28t. Location (Str.		per or Rurel Rou	ite Number,
a afte	4 Homicide	building, etc. (Specif))		City or Town,	Stete)		
To the Hospital or Attendit withing A hours after death. To the Funeral Director: A completely filled in by the funeral Medical Certification.		ysicien: To the best of my knowniner: On the basis of examination menner stated.						
ithiri outhe	29b. Signature and Mile of certifier	S. S. S. S. S. S. S. S. S. S. S. S. S. S	25	9c. License number	29	d. Dete signe	d (Month, Dey,	Year)
- s - ö	VII. 1	11 Ken		O.C.M.E.		July	29, 199	98
	30. Name end address of person who	completed cause of death (Item	23e) (Type Print)	-				
	THE DONE 11.	Ki 10		enn Street, B	altimore	Mary	land 21	201
State	31. Date filed (Month, Day, Year)	2. Degistra s Signa	TIT I	Cam Derecty D	ALCHIOLO.			
Registrar	JOT 31	19988 Julia D	avidson-Randa	处				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth TULY . 29 . 1998 HASLETT WARREN **Physician** /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** Church Hospital **Baltimore** Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) August 17, 1913 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 100 M 20 F Months 84 214-01-5673 **Director** Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho Other traumant svent, the Medical Examiner must be notined a 1 Yes 2 □ No Director Maryland -NA-Baltimore 10e. Straet and Number 10f. Zip Code 10g. Citizen of Whet Country? 4700 Harford Road 21214 United States Funeral CHWELYICHO ZOZAPROZOWZO Raca - American Indien, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 X Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Automobile 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be item 27 is marked of Warren W. Haslett Naomi Grove 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2706 Goodwood Road Baltimore, Maryland 21214 Twila E. Quesenberry / In-Law Baltimore 20a. Method of Disposition 20b. Place of Disposition (Neme of cometery, cremetory or other place) 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Pag Department Important: It eny Injury o 4 ☐ Donetion 5 ☐ Other (Specify) August 4, 1998 | Baltimore, Maryland Moreland Memorial 21. Signeture of Funeral Service Ucensee Milton J. Knight 22. Name end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause of each line. **Physician** ISCHEMIC HEART DISEASE Immediate Cause (Finel disaase or condition resulting in deeth) /Medical **Examiner** Due to (or es e consequança of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequença of): Physiclan/Medicai that initieted events resulting in deeth) Lest Records, P.O. Box 687 Due to (or es e consequence of) Part II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert !. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PARKINSON DISEASE by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes an autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Yeer) To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yas 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Numbar or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatura and title of cartifier

A. P. Wilsoni ~ 29c. License number 29d. Date signed (Month, Dey, Yeer) D17322 July, 29, 1998

State Registrar 32. Registrer's Signeture

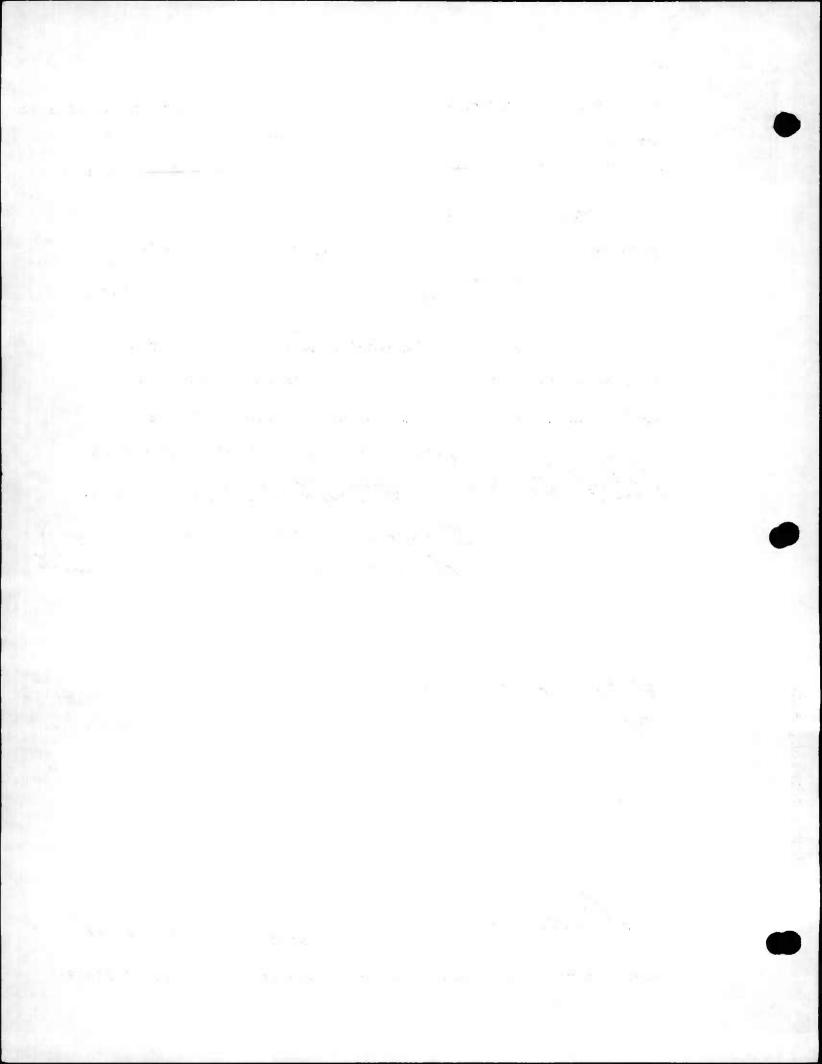
Sine Davidson-Randelle

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

HAME KNOWN TO SHAZIOPEN

Registrar



98-4197-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Crn State of Maryland / Department of Health and Mental Hygiene Jerome Johnson 23 part I,27,28a-f per MEO G-762 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** JOHNSON JEROME 23 1998 4c. County of Deeth 4b. City, Town, or Location of Deeth 1:16 P.M. * /Medical 4a Fecility Name (If not institution, give street end number) **Examiner** 3605 Reisterstown Rd. Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | TAN: | 16, 1955 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** M 2□ F 43 Yrs. **Director** MARY the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "naturaf", or items 23a or 28a-f ahow any injury or other traumatic evant, he Medical Examinet must be notified at anges. Yes 2□ No Directo MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 942 EXINGTON STREET USA. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - Americen Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0020 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MN KNOWN UNKNEWN UNKNOWA 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 2 ELEANOR FIELDS UNKNOWN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) ELMER LOUDEN (STEP-FATHER) 1942 W. LEXINGTON Date Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, cremetary or other place) 20a. Method of Disposition Burial 2 Cremetion 3 Removel from State 7-29-98 LANSDOWNE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) MT. ZION EMETERY of Funeral Service Lice 22. Name and Address of Fecility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE, MD. 21217 0 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory entest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel diseese or condition resulting in deeth) /Medical NARCOTIC INTOXICATION Examiner Due to (or es e consequence 45) Physician/Medicai Examiner The law requires that the death certificate be executed ettanding physicien end for usa es the bunal-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed pege 2 should 24e. Was an autopsy peen 1 XYes 2 □ No 1 Yes 2 □ No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence a Other (Specify) at scene P 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28b. Time of 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Neturel fouttury found 7/23/98 1XX Yes 2 □ No UNKNOWN 2 Accident 1:20 6XX Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3605 Reisterstown Rd. 4 Homicide UNKNOWN FOUND: Baltimore, Md.

1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated.

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Test print Pest Town C111 Penn Street, Baltimore, Maryland 21201

31. Deterfiled (Month, 1961, Yes) 1 1998 32. Registre's Signature Fundant.

29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year)

7-29-98

Division of Vital Records, P.O. Box 68760,

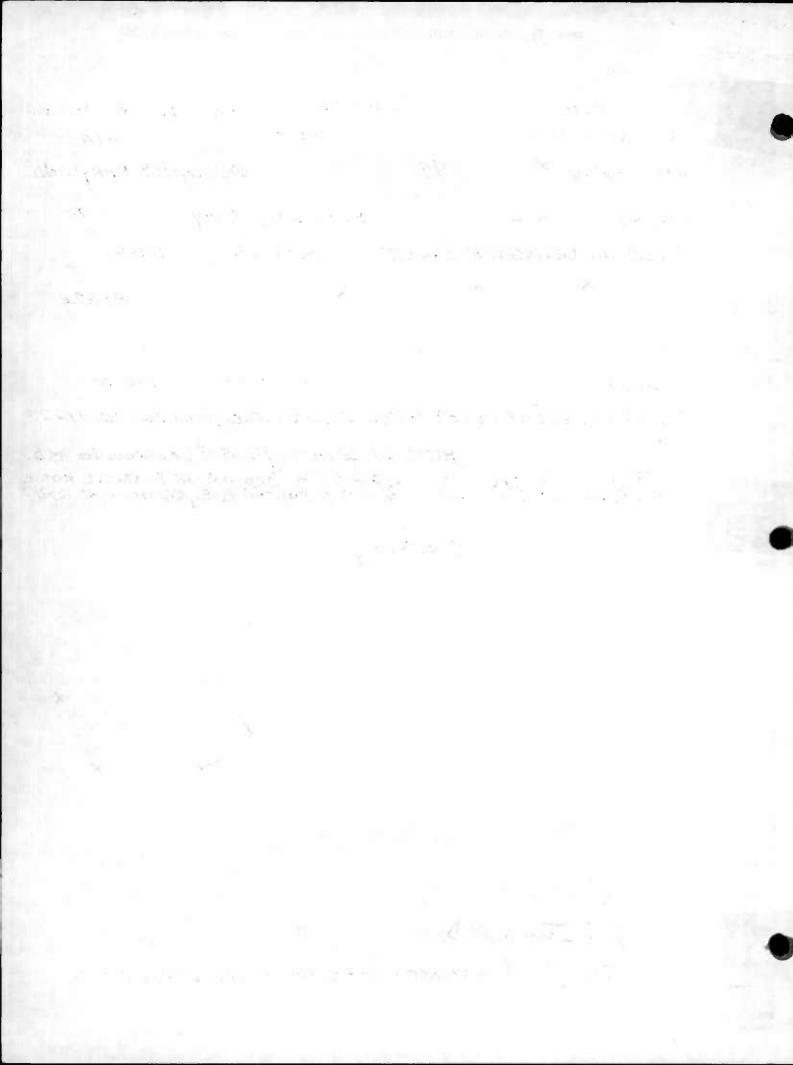
State Registrar

edical

29a. Certifier

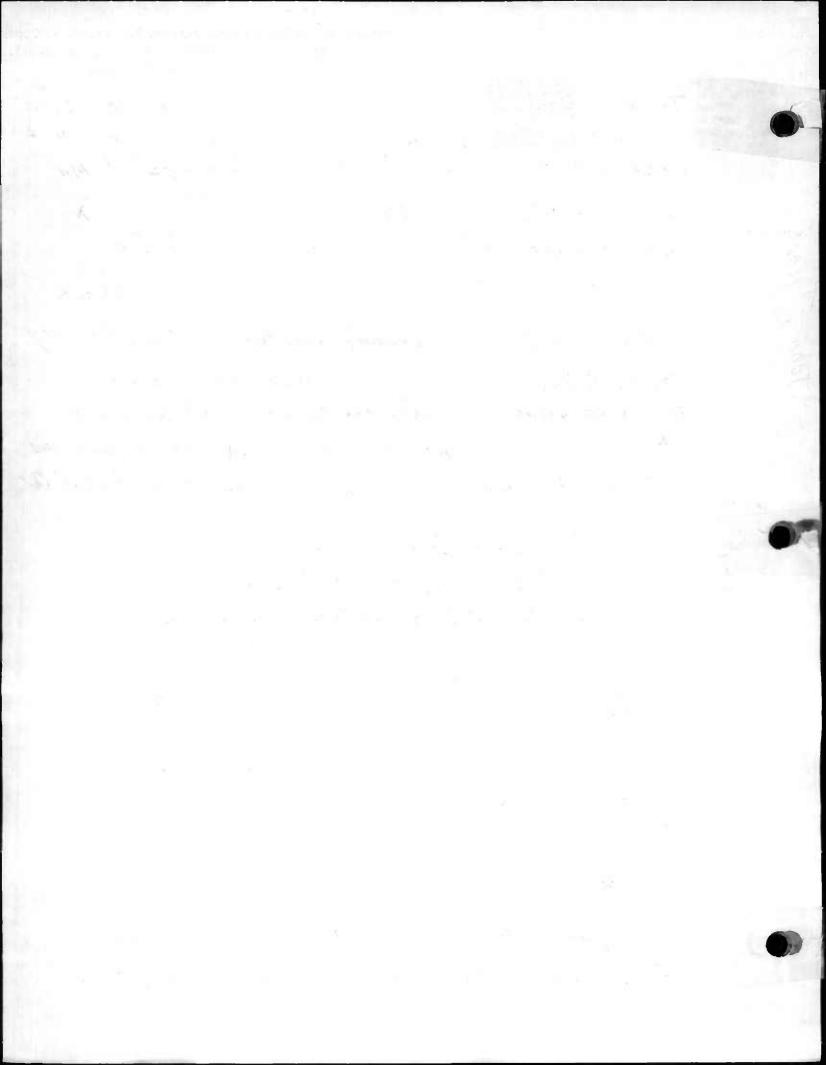
(Check only one)

29b. Signeture end title of certifier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Reg.	No.	4336/
-	Dhualai		Decedant's Neme (First, Middla, Last)		2	Date of Death	Day Yeer	3. Time of Death
1	Physici Medic/		TYPONE JOHNS			July	28, 1998	22:20
	Examin		4a. Facility Name (If not institution, giva street and number)	. 1	4b. City, Town, or Loca	ion of Death	4c. County of Death	./ 0
			MARYLAND GENERAL	Hospital	BALtin	nore	Cit	y NIA
	uneral irector		5. Social Security Numblar 6. Sax 7. Aga (In yrs. las 11/14 57 5-95-2	Yrs. If Under 1 Yaar Months Days	Hours Min.	Data of Birth (Month, Day, Ye	ar) 9. Birth Cou	nlaca (Stata or Foreign Intry)
and	ž		Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, 7	Town or Location				10d. Insida City Limits
Mery	-f sho	ō	1 0	3 ofto				1A Yas 2□ No
ONE.	, or items 23s or 28s-f show tanings must be notified at	Funeral Director	10e. Street and Number 621 940ver St.	10f. Zip Coda	05	_	Citizan of What Cou	untry?
	me 2	ner	11. Marital Status 12. Wes Decedant Evar in U.S.	13. Was Decedant of	Hispanic Origin? (Specitoan, Mexican, Puerto Ric	y Yas or No-	14. Race - Arner	
-0020 Phours effer	Examine	by	1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Datas:	1 ☐ Yas 2 ☑ No		an, atc.)	Specify: 3	LACK
5-C	netu	etec	15. Decedent's Education (Specify only highast grada complated)	16a. Decedant's Usual Occu (Give kind of work dona	pation a during most of working	16b	. Kind of Businass/I	
75 1215- within 72 ene.	hen Me	Completed	Elemantaly/Secondary (0-12) Collega (1-4or 5+)	LAUNALY	during most of working Assorter		Bush 1	-AUNdry
20	other t		17. Fathar's Name (First, Middle, Last)	2000	18. Mothar's Nema (F		fan Sumamal	
Maryland d2 should be file th end Mental Hy	o per	o Be	• 1.1.		ANNA M		2	
aryla should	meri	٩	19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Stree		-		in Coda)
	27 ia m r traum		^	1021 BRAN	4	Balto	md 21	217
altimore, mit. Pages 1 er	nt: If item 2 ry or other		20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State 4 Donetion 5 Other (Spacify)	ca of Disposition (Nama of patary, cramatory or other platery, C. Z. ON C.	ace)		Location - City or T	own, Stata
Baltil Permit. F Depertm	Important: If eny Injury or once.	-	21. Signatura of Funeral Sarvice Licensea	22. Nama and Addre	ass of Facility			
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	T,		23a. Pakt./ Entar tha disaase, or complications that caused tha daath. shock, or haart failura. List only one ceuse on each lina.	Do not anter the moda of dyl	ing, such as cardiac or r	aspiratory arrast,		Approximata Intarval Batwean
100	sician edical		Immediate Cours (Final	0				Onset and Daath
-	miner		Immediata Causa (Finel diseasa or condition rasulting in death)	ystunction	n			
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peta	ansit	Examine	b. End State	a consequence of):	DISEAS	E		
رةً إن	icien end buriel-transit		If any, leeding to immadiata causa. Enter Underlying		iency Sy	1		
6876 ficere	nysici he bu	edicai	Causa (Disaese or Injury	s e consequence of):	lency sy	ndron	ne	
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Bo)	tendi or use		d					
0.00	ed by the attend deteched for us	Physician	Part II. Other significent conditions contributing to death but not resulting	ng In tha undartying causa gi	ivan In Pert I.	23b. Did tobac	co use contribute	to the cause of death?
P.O	2 %	F	Il heroin use			1 🗆 Yes	2 No 3□ Pro	obably 4 Unknown
ords, P.O. Bor	been signed t should be det	d by	THE OUT ASS			Ode Wes so s	1000 24h V	Vara autoney findings
SO V	peen	Completed				24a. Was an au parformad	C	Vara autopsy findings vallabla prior to omplation of causa
I Rec	ate hes pege 2	F						f deeth?
in ta	certificate hes rector, pege 2		25. Was casa rafarred to medical		00 Disco (Disco) (2 No 1	☐ Yas 2☐ No
Sicial Si	is certific director,	o Be	axaminar?	VOutpatient 3□ DOA Ot	28. Placa of Daath (C		6 Other (Space	× 1
O 4	er this	n: T	27. Mannar of Death 28a. Date of Injury 28	Bb. Time of 28c. Inju		l. Describa how in		19)
ior ath.	r: Aft	atio	1 ■Natural 5 □ Panding (Month, Dey Year) 2 □ Accident invastigation		Yas 2□No			
Division of Vital Records, To the Heapital or Attending Physician: The lew requires the within 24 hours effer death.	To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicida 6 ☐ Could not be datermined 28a. Placa of Injury - At home building, etc. (Spacify)	a, farm, straat, factory, offica	28f	Location (Straat City or Town, St	end Numbar or Rur lata)	al Routa Number,
Offsi o	lled i							
Hos 24 ho	Fun	edical	29a. Certifiar (Check only one) Cartifying Physician: To the bast of my knowle Cartifying Physician: To the basis of examination and mannar stated.	dga, daath occurred at tha ti and/or invastigation, in my	ima, data and place, and opinion, daath occurred	dua to tha cause at the tima, data	(s) end mennar as and place, end dua	stated. to tha cause(s)
o the	omple		29b. Signatura and titla of certifier	29c. Licen:	se number	29d.	Data signed (Month,	, Dey, Year)
	-0		AGarcia, M.D.	8	9326		7 /	
h	7	-	30. Nama and address of person who completed cause of death (Item 23	3e) (Type, Print)			1100/7	r
-	1			10 MARyla	9326 nd GENER	eal +	toon to	al.
	Sta		31. Dete filad (Month, Day, Yaar) 132. Begistrar's Signatur	30 000	- C/100)		1	
	Registra	ar .	JUL 3 L 1998 G G Man Janual And	LACONCASEZ-				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3 Time of Death **Physician** Charles Dennis Jones /Medical City, Town, or Location of Deat 4a. Facility Nama (If not institution, give street and number) **Examiner** If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year, Birthplaca (Stata or Foraign Country) **Funeral** Davs 10XM 2□ F Months Hours Yrs. 216-10-9457 88 Maryland Director 1909 Usual Residence of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show 1 ☐ Yas 2 No Director Baltimore Co. Rosedale Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Nerns 23a 2368 Hamiltowne Circle 21237 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 🔯 No If Yas, Giva Yaar or Dates: 1 ☐ Naver Marriad 2 ☑ Married ò Completed by 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decadant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Diese Mechanic Railroad 6 yrs. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) and Mantal h Be and 2 should be James Jones Mary Betz 2 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Department of Health a Important: If Item 27 is any injury or other train size. 2368 Hamiltowne Circle Dorothy Redmond / Daughter Baltimore, MD Pages 1 20a. Mathod of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Most Holy Redeemer Cem. 7/31/98 Baltimore, Maryland 21. Signatura of Funaral Sarvice Licansee Michael E. Canapp 22. Name end Addrass of Fecility Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 23e. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** 4-5marks esoph /Medical immediata Cause (Final disaasa or condition resulting in daath) **Examiner** Dua to (or as a consequence of) Saquantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as e consequança of): Division of Vital Records, P.O. Box 68760 by Physician/Medical Dua to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Malnutri tran Anemia 1 Yes 2 No 3 Probably 4 Vinknown 8 24b. Ware eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Attanding Physician: Be 25. Was casa rafarred to medical axaminar? 26. Place of Daath (Chack only ona) 1 Yes 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Affert 5 Panding investigation s efter death.

Director: Aft din by the fur 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicide To the Hospital of within 24 hours of To the Funeral Di *Cartifying Physician: To the best of my knowledge, daath occurred at the time, data and placa, and due to the causa(s) and manner as stated.

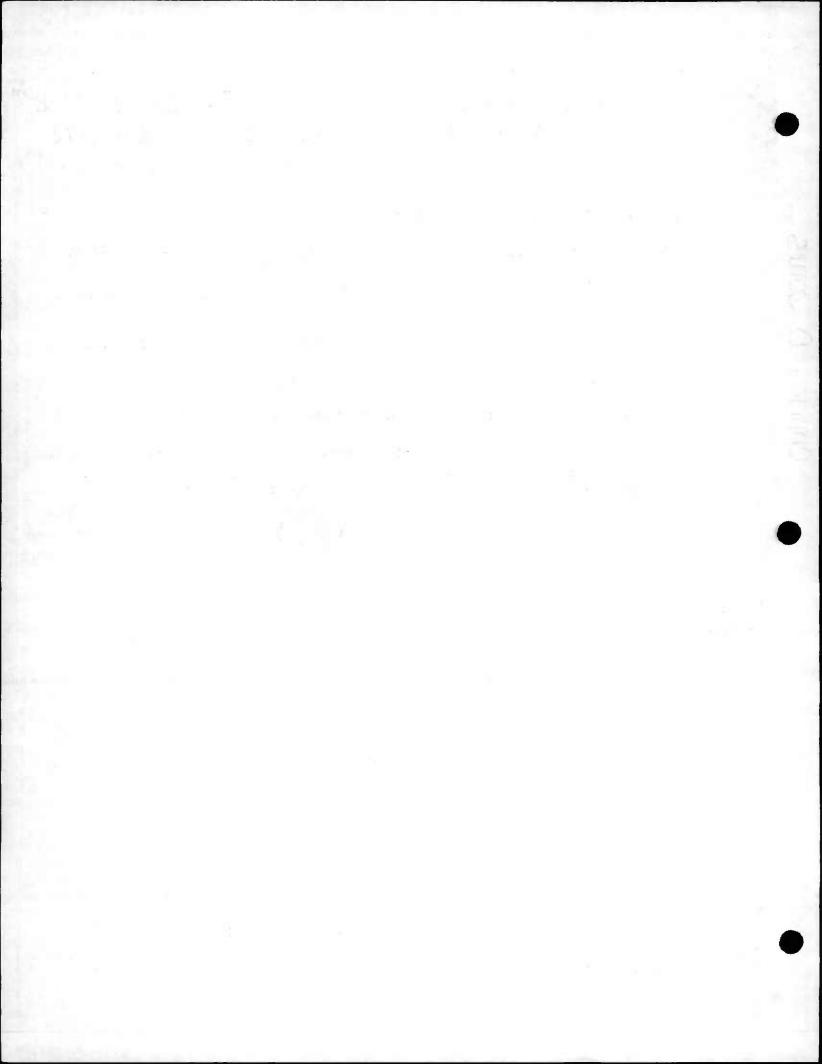
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical (Check only 29c. Licansa number D - 3 8 754 29d. Data signed (Month, Day, Year) 07 - 29 - 98 29b. Signatura and titlej of certifier M-D 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) 404 EASTERN BLUD, MD - 21221. WASEEM 31. Data filed (Month, Day, Year) 32. Aagistrar's Signatura

his Davidson-Randolle

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State

Registrar

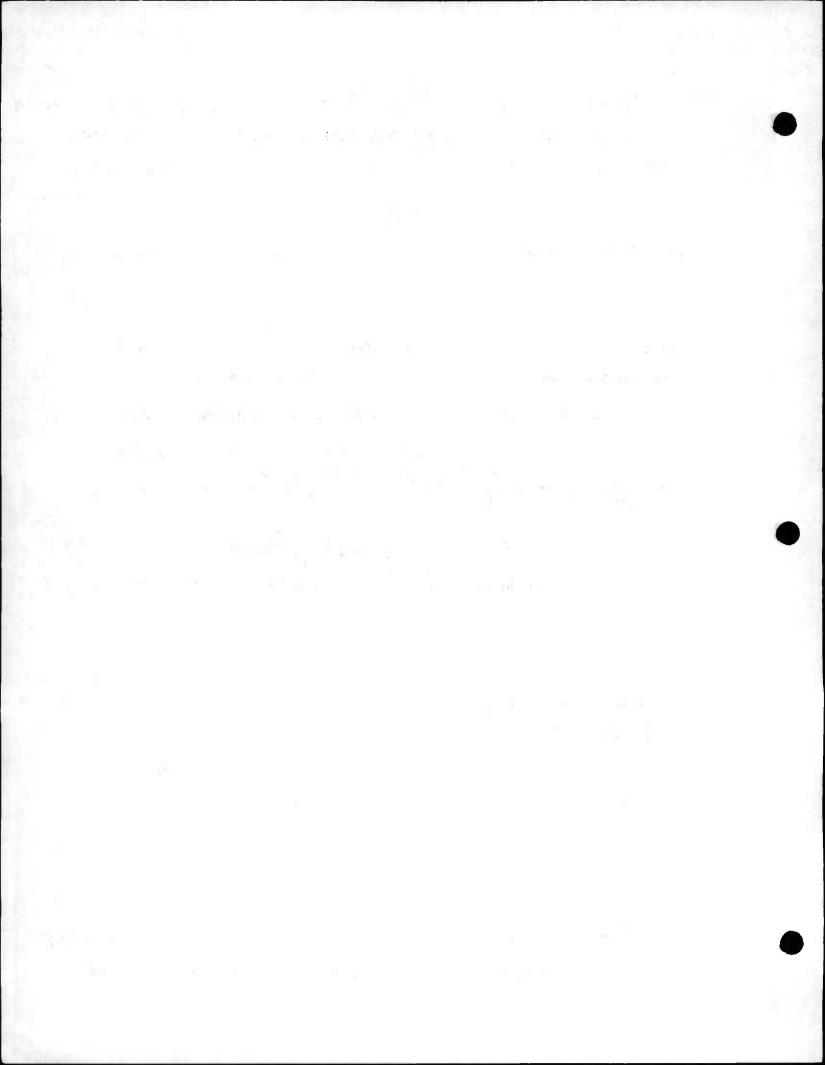


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** KELCH 11-20 AM 07 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ST. MARTINS HOME (LITTLE SISTERS OF THE POOR) CATONSVILLE BALTIMORE | If Under 1 Yeer | If Under 24 Hrs. | Nonths | Deys | Hours | Min. | AUGUST 19,1903 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 20%F Months 214-56-2294 MARYLAND Yrs. Director 94 Usual Residence of Decedent with the Maryland 10b. County liem 27 is marked other than "netural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at 10c. City. Town or Location 10d. inside City Limits Director 1 ☐ Yes 2X No MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 601 MAIDEN CHOICE LANE deeth v 21228 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If Item 27 is marked other than "netural", or ite any findury or other traumatic event, the Medical Examina 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 9 Specify 3 Nidowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER UNKNOWN DOMESTIC 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) HENRY JOSEPH LENNARTZ SUSANNA SCHMIDT 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARA J. VALEIKA (NIECE) 1103 LINDEN AVENUE - ARBUTUS, MARYLAND 21227 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, crematory or other pleca) Date 20c. Location - City or Town, State 1 □ Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD CEMETERY 7/31/98 BALTIMORE 21. Signature of Progral Service Licensee 22. Name and Address of Facility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 Pml. End the disease, or complications thet caused the death Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or huart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner a the burish-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Physician/Medical Due to (or es e consequença of) ě P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? rkinsons difease 1 Yes 2 No 3 □ Probably 4 Unknown Records, þ ementia 24b. Were eutopsy findings evelleble prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? certificate has page 2 The 1 Yes 21 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel deeth. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fi the 1 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homleide 1 XCertifying Phyelclan: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29b. Signature an offile of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) unkar 50. Name and address of person who completed cause of death (Item 23e) (Type, Print) BASKARAN . 345J- Williams AT . Bulhmar MD 21239 32. Registrer's Signature JUL 31 State Registra

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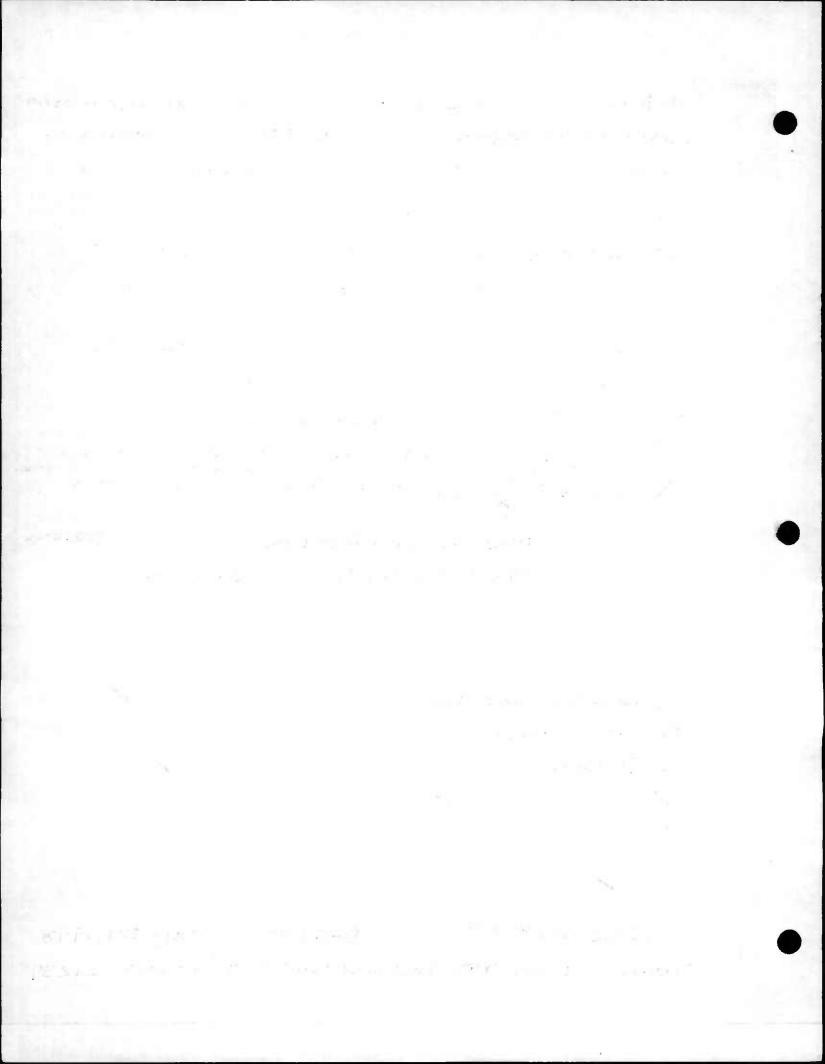
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 2. Dete S. Month **Physician** 12:38 PM Helen Keene 1998 /Medicai 4c. County of Deeth 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** Good Samaritan Itospital Baltimore Bultimore City 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. | R 4 | Yrs | Months | Deys | Hours | Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 NF 84 Yrs. **Director** 01/06/1914 Maryland 219-05-0743 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryle Department of Health end Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinet must be notified at once. 1 X Yes 2 □ No Director Baltimore Maryland 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? U.S.A. 2303 Pentland Dr. Apt. 109 21234 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Maid Housekeeping 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew Brown Francis Smith 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Irene Knox/Daughter 2303 Pentland Dr. Apt. 109
20b. Piece of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Desurial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 08/01/98 Landsdowne, Maryland Zion Cemetery 21. Signeture of Funeral Service License The Derrick C. Jones Funeral Hm. 22. Name end Address of Fecility 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pert1. Enter the disease, or complications that mused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one ceuse an asch line. Approximete fntervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) one nous /Medical Myocardial infarction **Examiner** Atherosclerotic Condiovascular Disease Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of) P.O. Box 68760 Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobecco use contribute to the cause of death? Alzheimer's dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed Previous Stroke 24a. Wes en eutopsy performed? dysphaguci 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital ial or Attanding Physicien: Tre efter death.

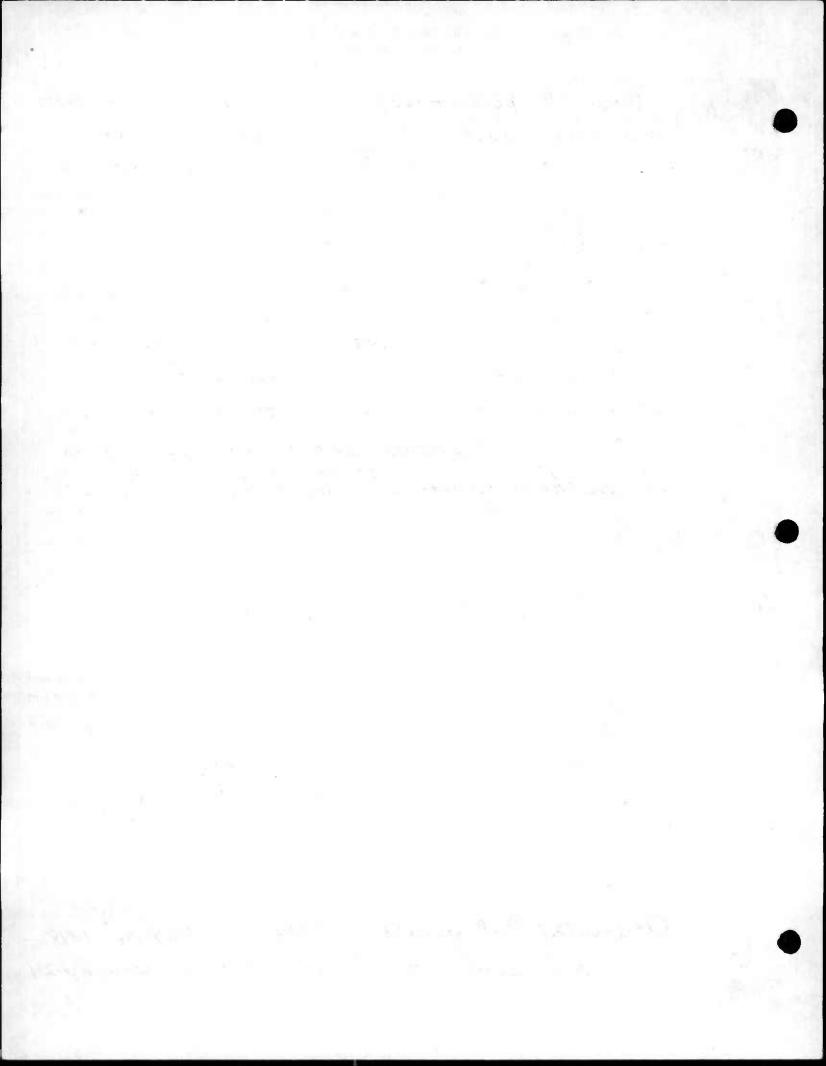
I Director: After this certificet ed in by the funeral director, pr 25. Wes case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpetient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funerel DI completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) July 29, 1998 040277 30. Name and address of person who completed cause of death (Item 230) (Type, Print)
Thomas 5. Wilson MD 5601 Loch Raven Blud. Baltimore Z1239 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 3 1 1998 we Davidson-Randall Registrar

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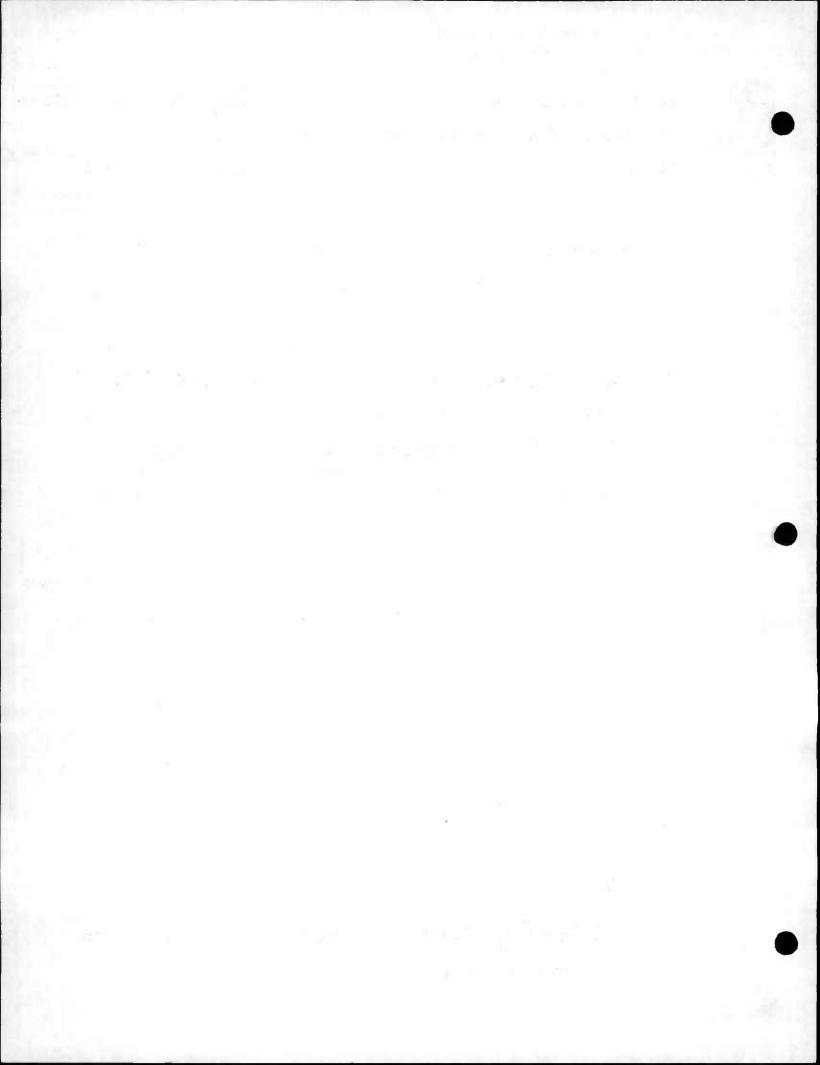


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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State of Maryland / Department of Health and Mental Hygiene

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3a o		3107 DUDLEY AV	E.			213		U.S.	•
al', or items 23a or 28a-f shov Examiner must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give		13. Was Decedent of If Yes, specify Cu	Hispenic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Ricen, etc.)	Black, W	maricen Indian, hite, etc.
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7 is marke traumatic	-	19a. Informant's Name/Relationship (T	10,0		Mailing Address (Stre		The second second		
5 ~ 5		DONNA MATARAZZ	O/ DAUGH						
		20a. Mathod of Disposition		20b. Place of	Disposition (Neme of cremetory or other p			20c. Location - City	
X = 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			MOUNT CE		1/30/98	BALTIM (ORE. MD.
Important: eny injury once.		21. Signature of Funaral Service Licens		Λ					
E SE		Erona 1	Calla				JNERAL H		MD. 21222
		23a. Part1. Erver the disaasa, o comp shock, o heart failura. List only o	lications that ceused	tha death. Do n					Approximate
/sician		snock, or heart failura. Use only of	ne causa on each li	ne.					Interval Batwean Onset and Death
ledical		Immediata Cause (Final disease or condition		Pneuma	nic.				2-2-1-11
aminer		rasulting in death)	a	Due to (or as a c					2-3eays
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35	Examiner	Sequentially list conditions,		Due to (or as a c					ofea.
TOTAL TOTAL		Sequentially list conditions, if eny, leading to immediate ceuse. Entar Underlying Cause (Disease or injury that initiated evants	C	nranic	obstructi	re pulma	mary di	sease	many year
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igned by the signed to detached	Physician/	Part II. Other significant conditions co	ntributing to death b	it not resulting In	the undarlying ceuse g	iven in Part i.	23b. Did to	1/	ite to the cause of death
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# 0	BeC	25. Was cese rafarred to medicel				26 Place of De	eath (Check only one		1 1 10S 90X NO
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年 西		27. Mannar of Death	28a. Data of Injui		ma of 28c. Inj		28d. Describe ho		Secry
ctor: After	atio	1 Natural 5 Pending 2 Accidant investigation	(World, De)	real) III		Yes 2 No			
Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28a. Place of Inju-	iry - At homa, fan	m, street, factory, office	•	28f. Location (Str City or Town		Rurel Route Number,
D in	Č			(0) 00//				, orale,	
65 4	edical	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and	daath occurred at tha or invastigation, in my	tima, data and plac opinion, daath occ	e, and dua to tha ca urred at tha tima, da	usa(s) and mannar ita and place, and d	as statad. ue to the cause(s)
Funera letely fille		29b. Signatura and title of certifier	0		29c. Licar	nse number	29	d. Date signed (Mo	nth, Dey, Year)
To the Funera	Σ								
he Funer pletely fil	Ž	Stana Stat	Keyne 1	on MD	99	3030	1	uly 29.	1998
To the Funera	W	30. Name and address of person who co	ompleted cause of d	eth (Item 23a) (7		3030	7	uly 29,	1998
To the Funera completely fille	M	30. Name and address of person who con Stasia Statt	ompleted cause of d	eth (Item 23a) (7		3030	1	uly 29,	1998



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer Month **Physician** Sieg fried Krute 1998 26 JUI.Y 1:45 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15 1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Hours Months Pennsylvania 88 Director 177-05-3087 Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Hunt Valley 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21030 300 International Circle Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: ò 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) **Electrical** Electrical Engineer n/a 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Freida Hultgren August J. Krute 2 19e. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Susan J. Foreman/Daughter 2306 Sandel Lane Westminster, MD 21157 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date July 30 Lake View Memorial park 1998 4 ☐ Donation 5 ☐ Other (Specify) Sykesville 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd Timonium, MD 21093 Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximale Interval Between Onset end Death **Physician** Congestive heart Failure Due to (or es e consequence of): Immediale Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enler Underlying Cause (Disease or Injury that initiated events resulting in dealh) Lest Physician/Medical Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dys motilit þ 24b. Were autopsy findings available prior to completion of ceuse of death? De Cydratio -24a. Wes an eutopsy Completed 22 No 1 ☐ Yes 1 ☐ Yes 2 No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Impatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. injury et Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 6 4

Division of Vital Records, P.O. Box 68750 should be det s certificate hes t director, page 2 s or Attending Physician: funeral efter deat 24 hours efter Funeral Dire letaly filled in b completaly To the within 2

Registrar

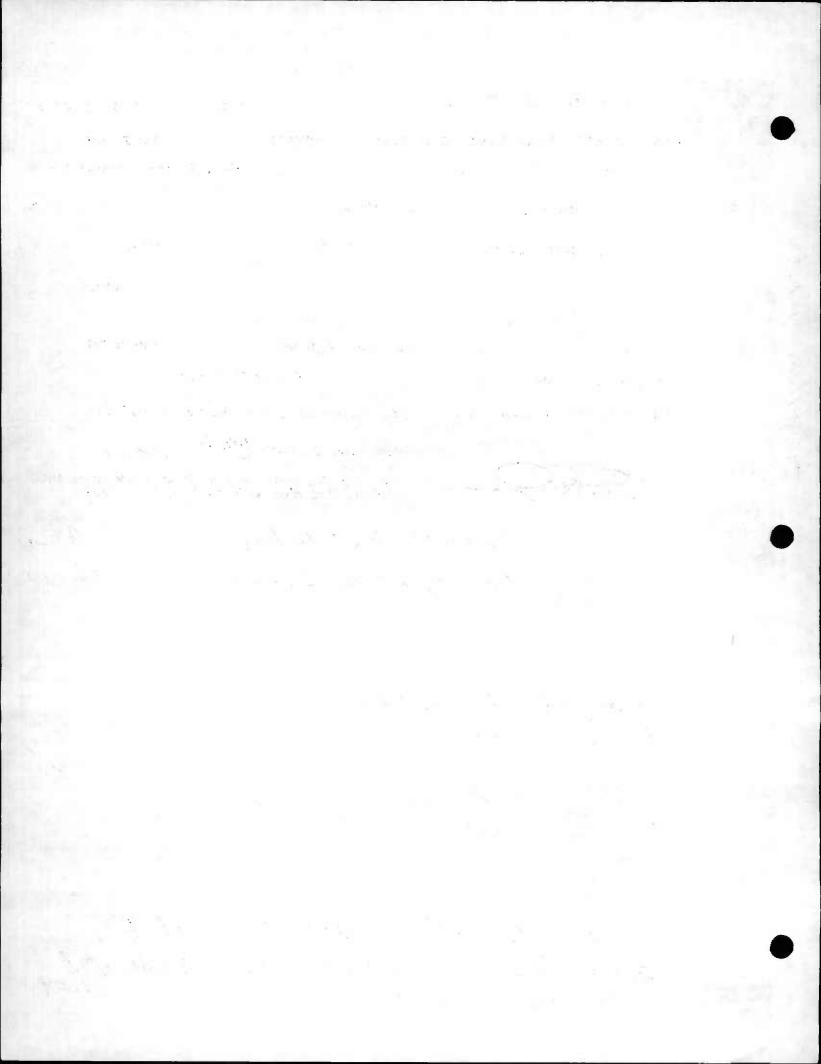
29e. Certifier

(Check only one)

ss of person who completed cause of death (Nem 23e) (Type, Print) 32. Registrar's Signature

NCharlist Suite 808 Baltine,

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 2. Date of Deeth Month Dey 28 July. 1998 5:46 P.M.

Physician /Medical Examiner

Funeral Director with the Maryland

Item 27 is marked other than "neturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be inclined at death permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "neturel", or iten eny injury or other traumatic event, the Wedgal Exercised

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

Examiner physician and s the burial-tran law requires that the death certificate be execu P.O. Box 68760. Physician/Medical SBS attanding use Jo signed by the a Division of Vital Records. þ Completed peen has page 2 certificata Aceptal or Attending Physician: 24 hours after death. Funeral Director: After this certifica diractor. Be 10 funeral Certification: in by

> 10 Registrar

State

edical

31. Date filed (Month, Dey, Year) JUL 31 1998

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest

25. Wes case referred to medical

5 Pending

Investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Deeth

1 Naturel

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier

29b. Signature an

30. Neme and

32. Registrar's Signature

28e. Dete of Injury (Month, Dey Year)

1. Decedent's Neme (First, Middle, Last) Jon Broughton Kasner 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 1871 Harcourt Ave. Crofton Anne Arundel If Under 24 Hrs If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) July 31, 1938 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) Deys Months Hours 18 M 2□ F Yrs 485 42 4401 59 Avoca Iowa Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Crofton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1871 Harcourt Ave. 21114 United States Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Merital Status Black, White, etc. 1X Yes 2 No
If Yes, Give
Year or Detes: 61-81 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 2d 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer State of Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Arthur H. Kasner Elizabeth Broughton 40 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Wife 1871 Harcourt Ave. Crofton Maryland_21114 Karen K. Kasner 20b. Plece of Disposition (Name of cametery, cremetory or other plece) July 29, Date 98 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremation 3 ☐ Removel from State The Huntt Crematory Waldorf Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. MUON 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pa . Enter the diseese, or com shock, or heart failure. List only hat caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as e consequenca of):

Due to (or es e consequença of)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

(Item 23e) (Typ

28b. Time of Injury

Pert II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy

24b. Were autopsy findings evaileble prior to completion of ceuse of deeth?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury et Work? 28d. Describe how injury occurred

1 Yes 2 No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1) Cortifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29d, Date signed (Month, Dev. Year) 29c. License number

23b. Did tobacco use contribute to the cause of death?

DHMH 16 Rev 6/95

To the 1
To the 1

 State of Maryland / Department of Health and Mental Hygiene

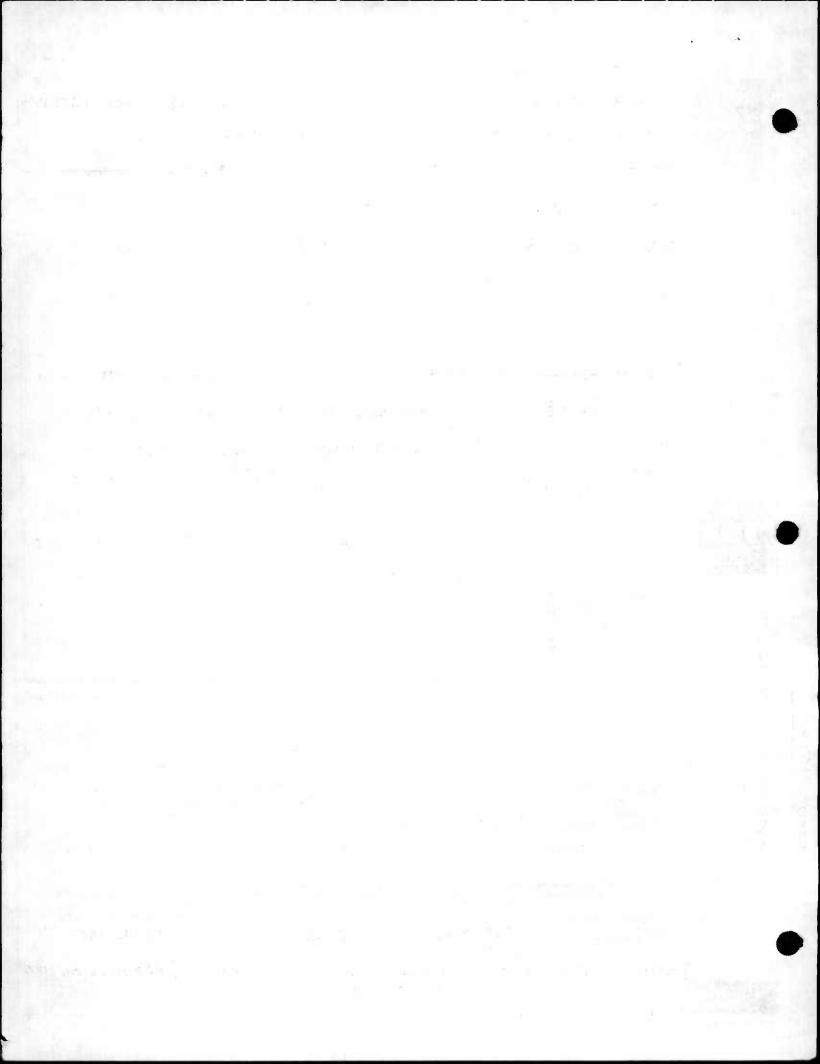
Item#9,17,18 per FH, #23apt1 perPhy G761 7/31/98EW Certificate of Death 1. Dacadent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Daath Month **Physician** HELEN HIBBARD LYONS JULY 12:55 pm. 21 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** CHARLESTOWN CARE CENTER CATONSVILLE BALTIMORE 5. Social Sacurity Number 7. Age (In yrs. lest birthday) if Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5/18/1900 9. Birthplaca (Stata or Foraign **Funeral** Months Davs Hours 1 M 20 F 213-10-2920 98 Yrs. Director MARYLAND Usual Residence of Dacadant with the Maryland 10a Stata 10b County show 10c. City. Town or Location 10d. Insida City Limits event, the Medical Examiner must be notified at MD BALTIMORE BALTIMORE Director 1 ☐ Yas 2 No 28a-f 10e. Streat and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ 6002 HEALY FARM ROAD 238 21228 U.S.A. Funeral filed within 72 hours after death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas ŽXXNo If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Spacify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Navar Married 2 Marriad ŏ 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE Š 3 X Widowed 4 ☐ Divorcad 'natural' Completed 15. Decadant's Education (Spacify only highast grada completed) 16a. Dacadant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elamantary/Sacondary (0-12) Collaga (1-4or 5+) CLERK MTA permit. Pages 1 end 2 should be filec.
Dapartment of heelin and Mental Hygic important: if item 27 is marked any injury or other 2000. Maryland 17. Fethar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be UNKNOWN HIBBARD James Hay Hibbard FT.LA (UNKNOWN) Drusilla Johnston 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rural Route Number, City or Town, Stata, Zip Coda) THERESA BACKOF 6002 HEALY FARM ROAD CATONSVILLE, MD 21228 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State NEW CATHEDRAL CEMETERY 7/24/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility WITZKE FUNERAL HOMES, INC. 21. Signatura of Funeral Service Lice 1630 EDMONDSON AVE CATONSVILLE, MD 21228 Pert1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intarval Between Onset and Daath **Physician** Immediata Causa (Final diseasa or condition resulting in daath) /Medical RESPIRATORY FAILURE MINUTES Examiner Dua to (or es e consequanca of): Examine Dementia The lew requires that the death certificete be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Dua to (or as a consaquence of): the bunel-trai Box 68760, igned by the attending physician be datached for usa es the burie Physician/Medical thet initiated avents resulting in deeth) Last Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Š 24b. Wara autopsy findings available prior to completion of cause of death? Completed ANEMIA 24a. Was an autopsy certificate has 1 ☐ Yas 2 20No 1 ☐ Yas 2 No Division of Vital Attending Physician: Be 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Othar: 4 Nursing Home 5 ☐ Rasidanca 6 ☐ Othar (Specify) 2 1 Yes 2 2No 1 ☐ Inpatient 2 ☐ ER/Outpatlant 3 ☐ DOA After this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Naturel death. 1 ☐ Yas 2 ☐ No 2 Accident aftar death 6 Could not ba 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 28e. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 | Homicida 6 To the Hospital of within 24 hours at To the Funeral D completaly filled Certifying Physician: To tha best of my knowledge, daath occurred at the time, date end place, and dua to tha cause(s) end mennar es stated.

Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, dete end placa, and dua to the cause(s) and mannar statad. 29a. Certifier Medicai (Check only 29b. Signeture and titia of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) JUN 21, 199A D26477 30. Nama and address of person who complated causa of death (Item 23e) (Type, Print) 711 MAIDEN CHOICE LANE, BALTIMORE NO 71228 BERUARD 12 Kozunsky, no 32. Register, Signature State Registrar

HELEN

LYOUS,

Name:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#26 perPhy G761 7/31/98 FW 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** LNER EE 4b. City, Town, or Location of Deeth 29 1998 02;09a /Medical 4a. Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** BALTI HORE
If Under 24 Hrs. 8. Dete of Birth
(Month, Day) AGNES HOSPITAL If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 218-76-9445 Months 1 M 2 F 8 Deys Yrs. Director MARYLAND Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23e or 28e-f sho other traumatic event, the Medical Examiner must be notified at BALTIHORE CIT 1 Yes 2 No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21229 USA

14. Raca - American Indien,
Bleck, White, etc. 610 WILDWOOD MARKWAY Funeral deeth 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after. Deperment of Health and Mental Hygiena. Important: If Item 271s merked other than "natural", or Item any Injury or other traumatic event 1 Yes 2 No It Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2No Specify: BLACK Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMENAKER OWN 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be RICHARD EVANS 2 MELVINIA JOHNSON 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ca of Disposition (Name of Det 20c. Location - City or Town, State (50 N JAMES LEE JR, 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Burial 2 ☐ Cremetion 3 ☐ Removel from State MT. ZION CEMETERY 8-3-98 LANSDOWNE, MARYLAND 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name end Address of Fecility

JOSEPH H., BROWN JR. FUNERAL HOME

2140 N. FULTON AVE., BALTIHORE, MD. 21217

enter the mode of dylng, such es cardiac or respiretory erfest,

Approximate Intervel Between Onset end Deeth Funeral Service Lic 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory erfest shock, or heart tailure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Heart Failure **Examiner** Examiner ettending physician and for use as the bunal-transit Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequenca ot): Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of) certificate has been signed by the signector, page 2 should be datached Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown þ 24b. Were eutopsy tindings evelleble prior to completion of cause ot deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funaral director, 25. Wes case reterred to medical Be 26. Plece of Deeth (Check only one) exeminer? Other: 5 Residence 6 Other (Specify) 10 Yes 2□ No 1 ☐ Inpatient 2 ☑ ER/Outpetient → DOA After this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident after death 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physiclen: To the best of my knowledge, death occurred at the time, dete end pleca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier Medical

29c. License number

Saint Agnes Haspita)

29d. Date signed (Month, Dey, Yeer)

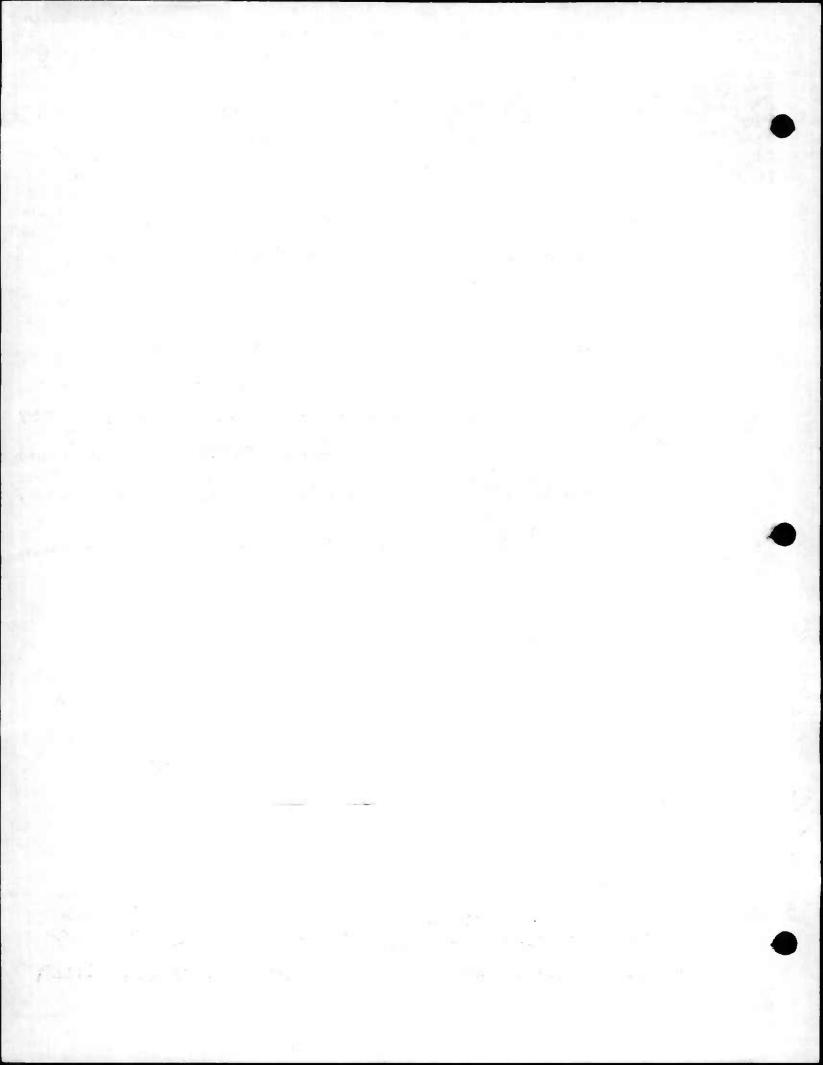
Attending

who completed cause of deeth (Item 23e) (Type, Print)

1998 32. Register significant

Physician

State Registrar 29b. Signature end title of certifier



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JULY **Physician** 9:55 am Doris Lancaster /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Bayview Medical (enter Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Months Deys 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 20 F 246-62-1487 70 Director February 9, 1928 USA Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No MARYLAND BALTIHORE CITY Director 10g. Citizen of Whet Country? 10e. Street end Number "natural", or items 23s AVENUE 21215 Funeral THORN DALE UJA. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Rece - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mantai Hygiene. If them 27 is marked other than "natural", or then any injury or other traumatic event Yes 2 No f Yes, Give Yeer or Detes: 1 Never Married 2 Warried 1□ Yes 2☑ No Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 9++GRADE College (1-4or 5+) HOME MAKER OWN 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be ATKINSON KEDMOND 2 BAKER MAMIE 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2917 THORNDALE AVENUE BALTIHORE MD. 21215 lece of Disposition (Name of Dete 20c. Location - City or Town, State MOSES LANCASTER (HUSBAND 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State CEMETERY 8-3-98 BALTIHORE, HARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility ROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIHORE, HD. 21217 re of Funeral Se Iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory drest, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Cardiopulmonary seconds. **Examiner** Due to (or es e consequenca of): Examiner 72 hours Acidosis Metabolic Respiratory and Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events. Due to (or as e consequence of): 14 days Acute Renal the attanding physician Failure Physician/Medical that Initiated events resulting in death) Lest Due to (or es e consequence of) the Hemodialy 415 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown (evebrovascular Azcident à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? Septicemia Aftar this certificate has Pulseless Electrical Artivity on July 20, 1998. 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Nnpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Locetion (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Division of Vital Records, P.O. Box 68760 The law requires that the death certificate bespital or Attending Physnours after deeth nerel Director: After this y filled in by the funaral di To the Hospital o within 24 hours af To the Funeral DI complataly filled in

21215-0020

Baltimore, Maryland

State Registrar

29a. Certifier

29b. Signeture end title of certifier

Johns Hopkins Bayview Medical (enter, 4940 Eastern Avenue, Baltimore, Maryland 31. Dete filed (Month, Day, Year)

JUL 31 1998

Selly J. F. MD

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

Felia Davidson

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

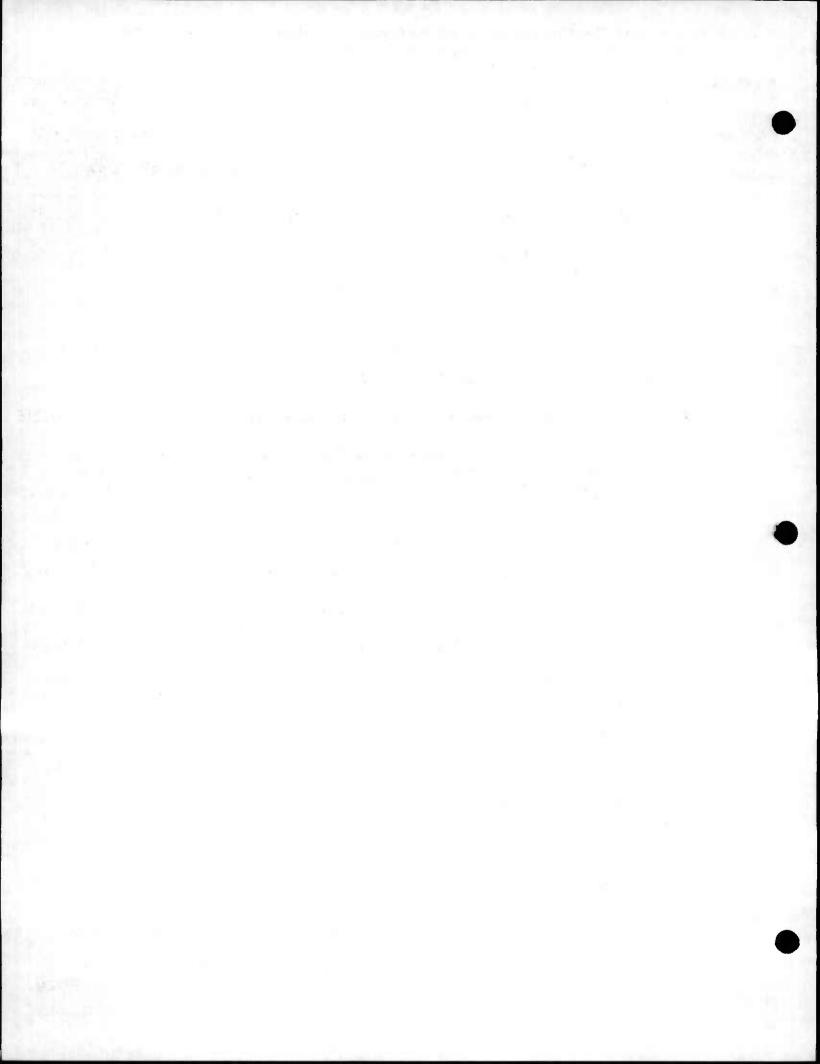
29c. License number

18040

29d. Dete signed (Month, Day, Yeer)

29, 1998

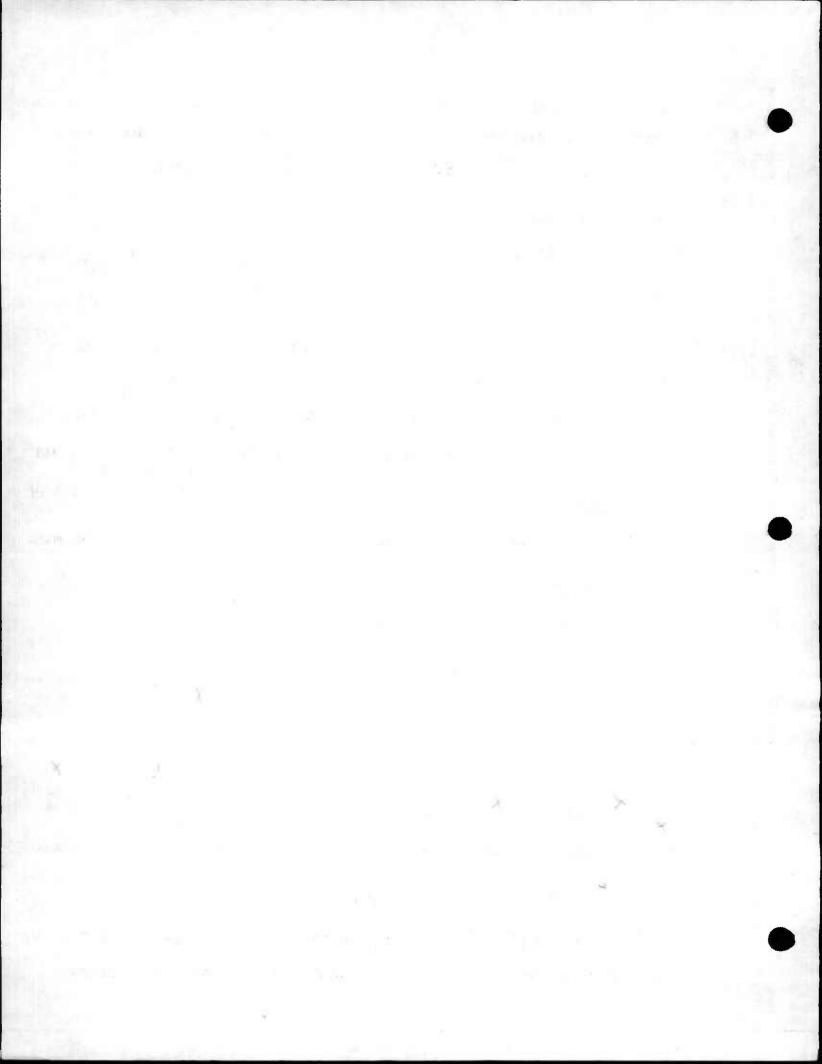
21224.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 27, JULY 1998 11:50AM MARIE FLIZABETH LLOYD /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson if Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sax Birthplace (Stata or Foreign Country) 10 M 20 F **Funeral** Months Days Min Yrs. Director 220-24-1740 JULY 7, 1916 MD. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ahow 7 is marked other than "natural", or itsms 23s or 28s-f shor traumstic avant, the Medical Examinar must be notified as 1 Yes 2 No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 7617 HILLENDALE 20 21234 U.S. A. 12. Was Decedent Ever in U,S. Armed Forcas?

1 Yes 2 No 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Giva Yeer or Detes: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hyglene. Important: If Itam 27 Is marked other than "na any Injury or other traumatic avant, tra Mediconce. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME HOMEMAKER AT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELSIE EGE M. STOLZENBACH FREDERICK 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) BALTIMURE, MO. 31336
Date 20c. Location - City or Town, State SON RONALD SCHREIBER 41 LAUREL PATH CT Baltimore. 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MORELAND MEMORIAL PK. 17-30-98 PARKVILLE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. BALTIMORE MO. 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Physician Immediate Ceuse (Finat diseese or condition resulting in deeth) /Medical 55 MIN. ACUTE MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of) Physician/Medical Examine attending physician and for use as the burial-mansit Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this funeral 27. Manner of Deeth 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/■ Natural 2 □ Accident 5 Pending investigation death. 1 Yes 2 No or Attand after death Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a • Funeral 29a. Certifier (Check only one) To the Hospi within 24 hou To the Funer completely file 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as steted. Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16492 30. Neme and eddress of person who complated cause of death (frem 23a) (Type, Print) 7620 YORK ROAD, TOWSON, MARYLAND 21204 P. M. D., DIZON, BEATRIZ 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State Wa Durday Registrar JUL 31 1998

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Alexander eech 2.00 Am 28 1998 4c. County of Death July /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street end numbar) **Examiner** Baltimore Samantan Baltimore Hospita 8. Data of Birth (Month, Dey, Year)
Jan. 22, 1919 If Undar 1 Yaar Months Deys If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours 1⊠M 2□ F Yrs 212-18-8749 79 Director Georgia Usuel Residanca of Decedent the Meryland 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1⊠Yes 2□No Director Maryland N/A Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with 2927 Berwick Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Giva Yaer or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 Navar Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Health of Defice. Life Insurance Elementery/Secondary (0-12) College (1-4or 5+) Company 12th Grade Agent 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Hugh Houzel Leech Marie Cefalu 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code) Dorrence M. Leech/Wife 2927 Berwick Avenue, Baltimore, Maryland 21234 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 7/30/98 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XI Cramation 3 ☐ Ramoval from State Baltimore/Washington Crematory Laurel, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signetice of Funeral Service Licensee 22. Name end Address of Fecility
John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 anuta Homos ther the disaase, or complications that caused the deeth. Do not enter tha moda of dying, such as cerdiec or respiretory errast, haart fallura. List only ona causa on aach line. Approximata Intarval Batween Onsat and Deeth **Physician** Immediete Ceuse (Finel disaase or condition resulting in deeth) /Medical Examiner Bue to (or es e consequence of): Physician/Medical Examiner neumonia The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate ceuse. Entar Underlying Ceuse (Diseese or Injury that initiated events rasulting in deeth) Last pue Due to (or as a consequence of) the bunal-ma ettending physician for use es the buna Box 68760. Due to (or es e consequence of): P.O. Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown none Records, þ 2 24b. Wara autopsy findings evailable prior to completion of ceuse of death? Completed 24a. Was en eutopsy certificate 1 ☐ Yes 25 No 1 □ Yes 2 □ No Division of Vital or Attending Physician: director, Be 25. Was cese rafarred to medical exeminer?

1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Mangar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After ? 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be datarminad 3 ☐ Sulcide 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street end Number or Rurel Routa Number, City or Town, Stata) 4 Homicida Certifying Physicien: To tha best of my knowledga, daath occurred et tha tima, data end plece, end dua to the cause(s) end mannar es stated.

| Medical Examinar: On tha basis of axaminetion end/or invastigation, in my opinion, daath occurred et the time, date end place, end due to the ceusa(s) and mannar stated. Medical

29c. Licansa number

29d. Date signed (Month, Dev. Yaar)

State Registrar (Check only

560

29b. Signature end title of certifier

31. Data filed (Month, Day, Year) JUL 31 1998 32. Registrar's Signetura Julia Davidson-Randelle

Blud

Raven

30. Name end eddress of person who complated ceuse of deeth (Item 23a) (Type, Print)

Loch

P-12557

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Mecchia July 28,1998 Pierina M. 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Genesis Elder Care Nursing Home Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 89 Yrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 215-01-7635 1□M 20F Months Deys Hours Italy Usual Residence of Decedent 10b. County Baltimore 10c. City, Town or Location Rosedale 10d. Inside City Limits 1 ☐ Yes 2 No 10f. Zip Code 21237 10e. Street end Number 6701 Golden Ring Rd. 10g. Citizen of Whet Country? USA 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Married 2 Married 1 ☐ Yes ➢ No If Yes, Give Year or Detes: 1 ☐ Yes 2 XNo Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Seamstress Retail Clothing 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John Vachino Maria Lagna 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Sylvia Austin / daughter 6701 Golden Ring Rd. Rosedale, MD 21237 20b. Pleca of Disposition (Name of cemetery, cremetery or other place) Most Holy Redeemer 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) 7-31-98 Baltimore, MD 21. Signeture of Funeral Service Licensel 22. Name and Address of Facility CVach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 envo 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Approximete Intervel Between Onset end Deeth a. CARDIO PULMONARY Due to (or es e consequence of): tmmediete Ceuse (Final disease or condition resulting in deeth) ALZHIEMERS Due to (or es e consequenca of): DEMENTIA Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): ACRAL RETES MELLITUS Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 4 Onknown 3 Probably 1 ☐ Yee 2 ☐ No 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed? 1 Yes 20 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent Other: 1 Yes 2 No 3□ DOA 41 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

Division of Vital Records, P.O. 2 The law After this certificate has page 2 I or Attending P after death. I Director: After 2 To the Hospital of within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Director

Funeral

þ

Completed

r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at

o filed within 72 hours after death of Hygiene.
other than "natural", or items 23

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 Is marked or

any Ir

Physician

/Medical Examiner

Physician/Medical

á

Completed

Be

10

Certification:

Medical

(Check only one)

29b. Signeture end title of certifier

erredu

Baltimore, Maryland 21215-0020

the Maryland

State Registrar

31. Date filed (Month, Dey, Year) JUL 31 1998

CC

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Place Ballinere MD Julka anel 32. Registrer's Signature Archa Devidson

DHMH 16 Bev 6/95

in gree

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #1 Per MD Film G761 7-31-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Deeth Yaar Month **Physician** Mary Elizaabeth Morgan 1455 4b. City, Town, or Location of Death 4c. County of Death /Medical 4a Facility Nama (If not institution, giva street and number) Examiner Sacred Heart Hospital Cumberland Allegany If Undar 24 Hrs. If Undar 1 Yaar 7. Aga (In yrs. last birthday) (Year) 1930 9. Birthplaca (Stata or Foreign 5. Social Security Number **Funeral** 1□ M 25 F 67 Maryland Yrs 220-26-9280 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yas 2 🖾 No Midlothian Maryland Allegany Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda P.O. Box 398 21543 II.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc 1 ☐ Yas 2 🛣 No If Yas, Giva Yaar or Datas: 1 ☐ Never Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Spacify: White þ 3 DWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) University Maintenance Worker 12 0 18. Mothar's Nama (First, Middla, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Be Elizabeth Hamilton Harry Elmer Keister 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 11302 Blan Avon Road, S.W., Midlothian, Maryland 21543 Gerald C. Morgan -son 20b. Place of Disposition (Nema of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 Donation 5 Other (Specify) 21. Signature of Enteral Service Lice State Anatomy Board, 655 W.Baltimore Street Wade / Director Baltimore, Maryland 21201 Erriar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Daath **Physician** Immediata Cause (Final diseasa or condition resulting in death) METASTATIC ESOPHAGETY CARCINOMA /Medical YEARS Examiner Dua to (or as a consequance of): Examiner The law requires that the death certificate be executed attending physician end for use as the burial-tran Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequanca of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown DEHYDRATION Records, ģ 24b. Wara autopsy findings available prior to complation of causa of deeth? been sig 24a. Was an autopsy parformad? Completed s certificate hes t director, page 2 s 1 ☐ Yas 2 ☐ MÓ 1 Yas 2 1 M Division of Vital or Attending Physician: director, 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 N 0 1 Hipatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Daath 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred Certification: After 5 Panding Invastigation 1 UNetural death. 1 Yas 2 No after death Director: A 2 Accidant 6 ☐ Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. edical

hin 24 hours at the Funeral Di npletely filled in Hospital within 2 To the I complet To the

> State Registrar

29a, Cartifiar

31. Data filad (Month, Day, Year) JUL 31 1990

JOSE 7.

29b. Signatura and titla of certifian

32. Registrar's Signatura guila Davids

JR. MO

30. Neme and addrass of person who complated causa of death (Itam 23e) (Type, Print)

LOVERLA

29c. Licansa number

D50844

29d. Data signad (Month. Dav. Year)

912 SETON DRIVE, CUMBERLAND, MD 2,502

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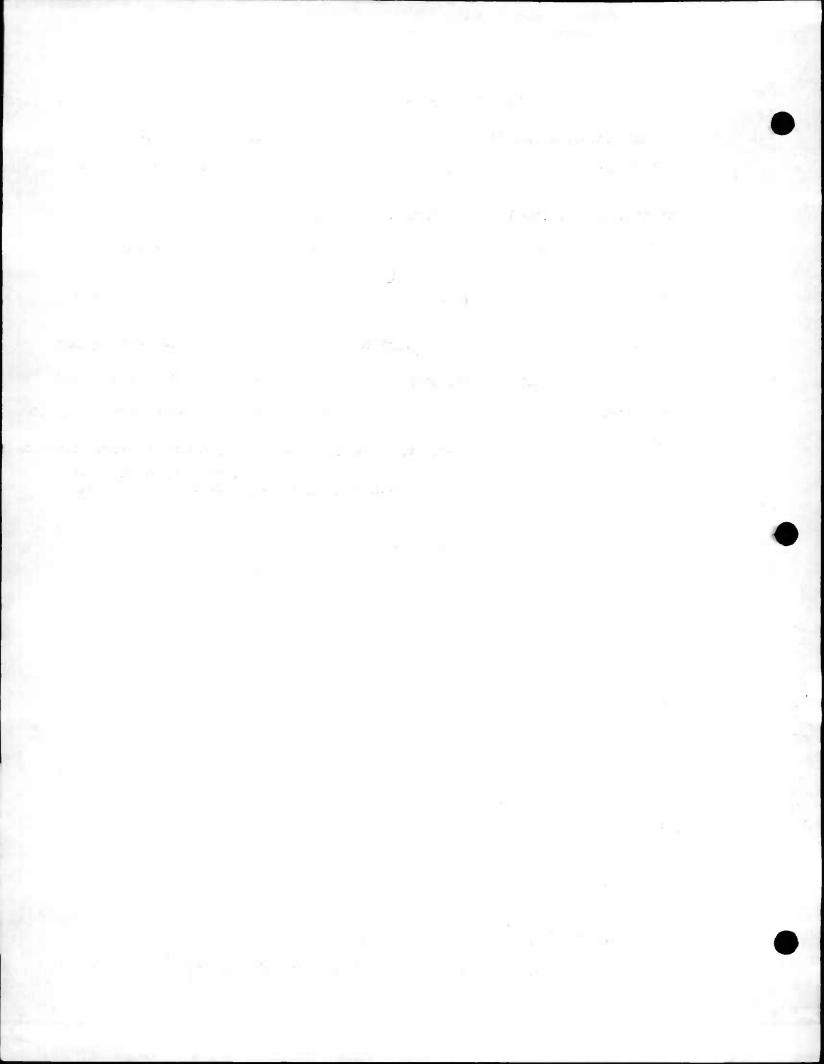
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State of Maryland / Department of Health and Mental Hygiene 9 8

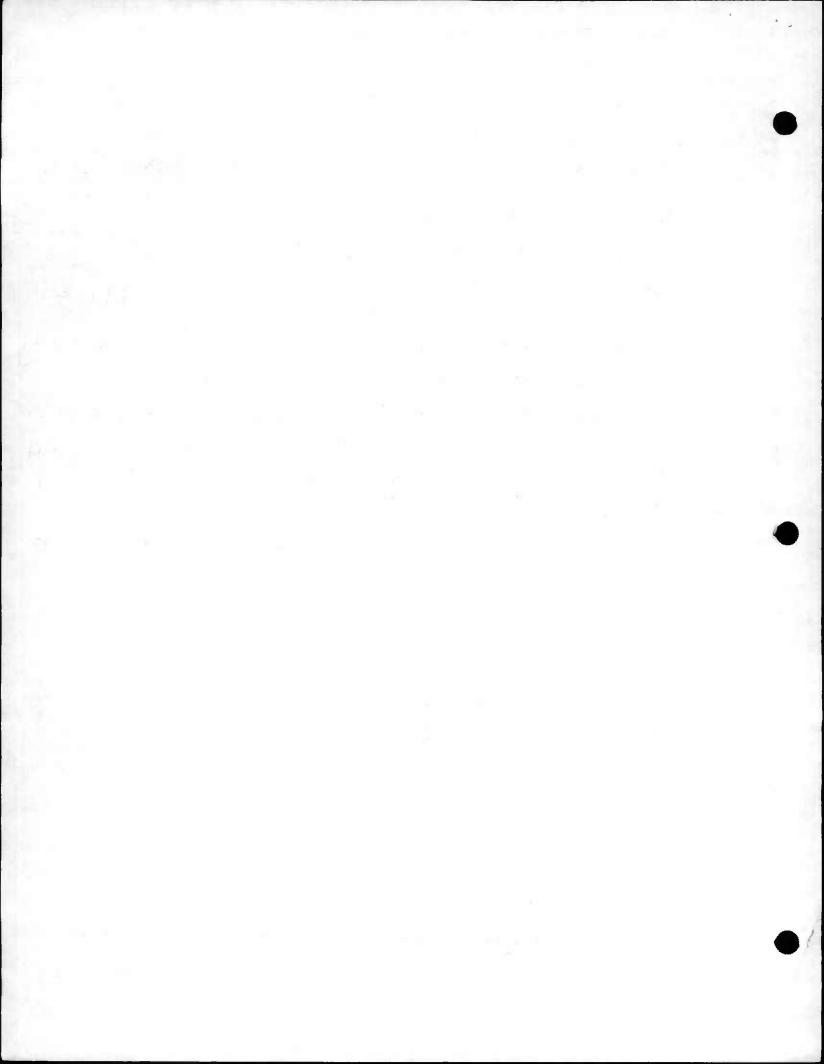
23382

							Ce	rtificate of	Death		Reg. No.	<u> </u>		<u></u>
			1. Decedent's Neme	(First, Middle, L	.ast)			Wat		2. Date of I	Deeth	Maria	3. Time of De	eath
	Physic /Medi				Carl	J. McH	enry			Month JULY	Dey 27	Yeer 1998	11:15	P.M.
	Exami		4a. Facility Name (If	not institution, g	ive street and numb	er)			4b. City, Town,	or Location of De	ath 4c. Count	y of Death		
			Union 1	Memoria]	l Hospita	l			Baltim	ore	N	/A		
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	rylar		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation				1	10d. Inside City L	Limits
	Me Ma	cto	Maryland	Anne A	runde1	Ba	altimo	re					1 ☐ Yes 2	X No
	th th	ire	10e. Street and Num	ber				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	sth with the Marylar 23a or 28a-f show ust be notified at	a L	626 Feri	nhill Ro	oad			212	26		U.	S.		
	dee	Funeral Director	11. Marital Status		12. Was Decade Armed Force	ent Ever in U	,S. 13.	Was Decedent of I	Hispanic Origin	(Specify Yes or I		ca - A <i>m</i> erio	can Indian,	
	or its	F	1 Never Marrie	_	1 ⊠ Yes 2 If Yes, Give			1 ☐ Yes 2 DXNo		ieno moan, etc.)				
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	View Men	မ			Charles V	. McH	-			Mary			lable)	
	Aar 2 sh 2 sh end is m		19e. Informant's Na					ng Address (Stree						
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	or of H		20a. Method of Dispo		☐Removal from Sta	20b. F	Place of Dispo cemetery, crea	osition (Name of matory or other pla	ice)	Date	20c. Location	- City or To	own, State	
	Pag ment ant::		4 ☐ Donation 5				. Stat	e Vetera	n Cem.	7/31/9	8 Crowns	ville	, Maryla	and
	Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, in Medical Examinar must be notified at once.		21. Signature of Fun	eral Service Lice	ensee	66	1 2	2. Nama and Addre	ess of Facility	Conce	Funeral	Home	P.A.	
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	/Medical		Immediate Cause (F	inal	Overed	halmina	Sepsion					İ	2 .	
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		otate of maryland	Certificate of Death	Reg. No.	. 3 3 8 3
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Physic /Med		ELLEN	MOORE	July 28 1998	11:20 pm
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		Good Samaritan	HOSP. Balt	timore NA	
Funeral Director		5. Sociel Security Number Cl2-24-8334 G. Sex 1 M 28F 7. Age (In yrs. less) Usuel Residence of Decedent	t birthday) If tinder 1 Year If Under 24 Hrs Months Deys Hours Min	s. 8. Dete of Birth (Month, Dey, Year) 9. Birth Could 22 1928	plece (Stete or Foreign ntry)
ylend		10a. Stete 10b. County 10c. City, 1	own or Location		10d. Inside City Limits
Mer sel	to	MD Baltimore Ba	Itimore		1 ☐ Yes 2☐ No
or 28	Director	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Cou	ntry?
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2 ho	ba	15. Decedent's Education	6e. Decedent's Usuel Occupetion	16b. Kind of Business/ir	ndustry
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should to	To	Charles S. Jones SR	. Ida	LONES	
2 sho end is me		19e. Informent's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or F	Rural Route Number, City or Town, Stete, Zi	o Code)
of Heelth Itam 27 other tr		LINDA JONES-NIECE	4114 Fall staff	Rd. Balta Md.	21215
Page nent o int: If iry or		1 Describer 5 Other (Specific)	e of Disposition (Neme of elery, cremetory or other place)	Date 20c. Location - City or Ti	own, Stete
pemit. Page Department of important: If any injury or		21. Signature of Funeral Service Licansee	22 Name and Address of Fecility 7 Wm C, March 7 4300 Wabash	Funeral Home WE Aue. Dalto. Md	54, The 21215
7		23a. Part. Enter the disease, or complications that caused the death. I shock or hear dailure. List only one cause on each line.			Approximate Intervel Between
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that the death co	Physician	Pert II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Pert I	23b. Did tobecco use contribute t	o the cause of death:
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tending Ph leath. tor: After th the funeral	tion	1 Naturel 5 □ Pending (Month, Dey Year)	b. Time of Injury et Work? M 1 Yes 2 No	200 Dodding tight injury cooping	
or Attending efter death. Director: After I In by the funer	Certification:	2 Accident Investigation 3 Suicide S Could not be determined 28e. Pleca of Injury - At home building, etc. (Specify)		28f. Location (Street end Number or Run City or Town, State)	el Route Number,
To the Hospital or Atte within 24 hours etter de To the Funeral Directo completely filled in by the	edlcai C	29a. Certifier (Check only one) Certifying Phyelcien: To the best of my knowle 2 Medical Examiner: On the basis of exemination end menner steted.	dge, death occurred et the time, dete end plac end/or Investigation, In my opinion, deeth occ	a, end due to the ceuse(s) end menner es s urred at the time, dete and placa, end due t	steted. o the ceuse(s)
o the	Me	29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month,	Dey, Yeer)
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1-		Toured whaten Jak	999 P10589	July 28, 1	סדד
0		30. Name and edoress of person who completed cause of oeath (item 23	(Type Print)	an Hospital of Hary	10 10
		MOHAMED KHARFAN DABAJA, MD	The Good Samaril	an mospilal of mary	land, Inc
Sta Regist		31. Dete filed (Month, Dey, Yeer) 32. Register's Standard	Inn Bridge		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Horace Cordel1 McElhiney July 30 1998 1:30 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 8. Date of Birth (Month, Day, Year) Oct. 14,1930 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Months Days 10XM 2□ F Hours Min 67 413 44 5576 Tennéssee Usuel Residence of Decedent 10a State 10d. Inside City Limits 10b. County 10c. City, Town or Location n/a Maryland Baltimore ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4618 Schley Ave. 21206 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Yes, Give Specify: 3 Widowed 4 Divorcad Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mass Transit Admin. Dispatcher Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otis Ivan Lucas McElhiney Grace Irene Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty McElhiney / Wife 4618 Schley AVe., Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition cometery, crematory or other place)

Green Mount Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/31/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral S CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 amam 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death multiple cerebral injerctions Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? mellitus 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner

Examin

Physician/Medical

Completed

89

To

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

permit. Pages 1 end 2: Department of Health an Important: If Item 27 is 1 any Injury or other treum

Physician

/Medical

Examiner

Director

Funeral

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Be

Funeral

Director

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end 2 should be filed within 72 hours after death with the Maryrer leath and Mentel Hygiene. Im 27 Is marked other than "natural", or frams 23s or 28s-f show her traumatic event, the Medical Examine. Insist be not tradial.

Baltimore, Maryland 21215-0020

1:25am

the burial-tra 58 657

ò

CElhurey, Horace

Registrar

29b. Signature and title of dertifier

5 Pending investigation

6 Could not be determined

29c. License number 125205

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

und 30. Name and address of person who completed cause of deep (Item 23a) (Type, Print)

6701 N. Charles St. Balto and 2120x

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

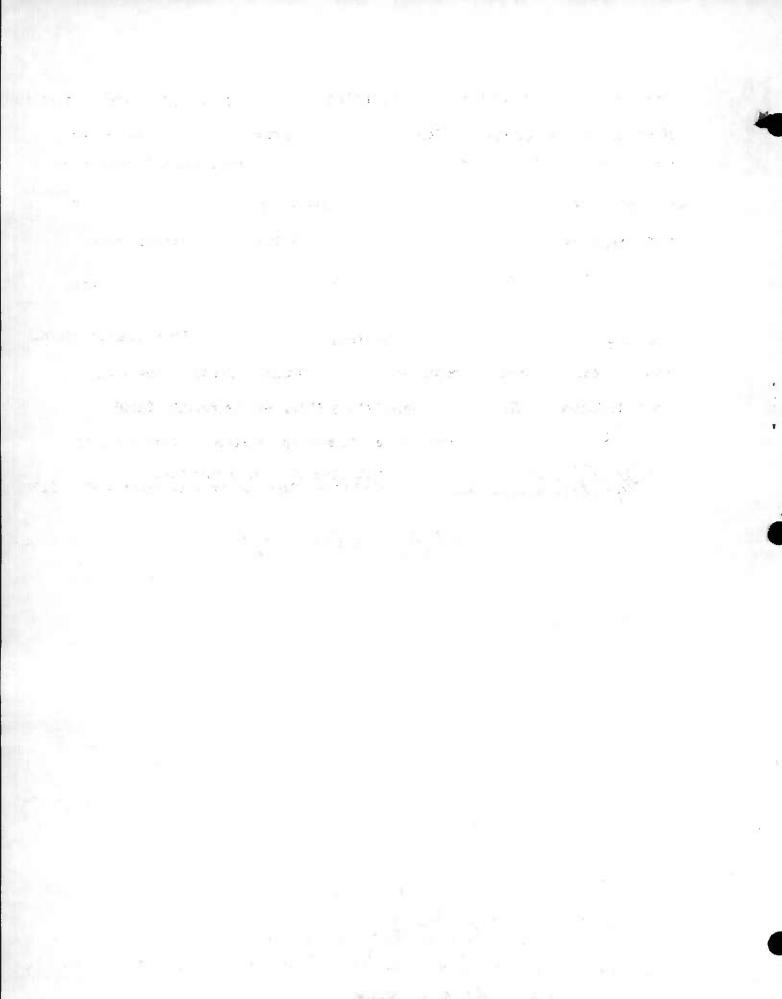
32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

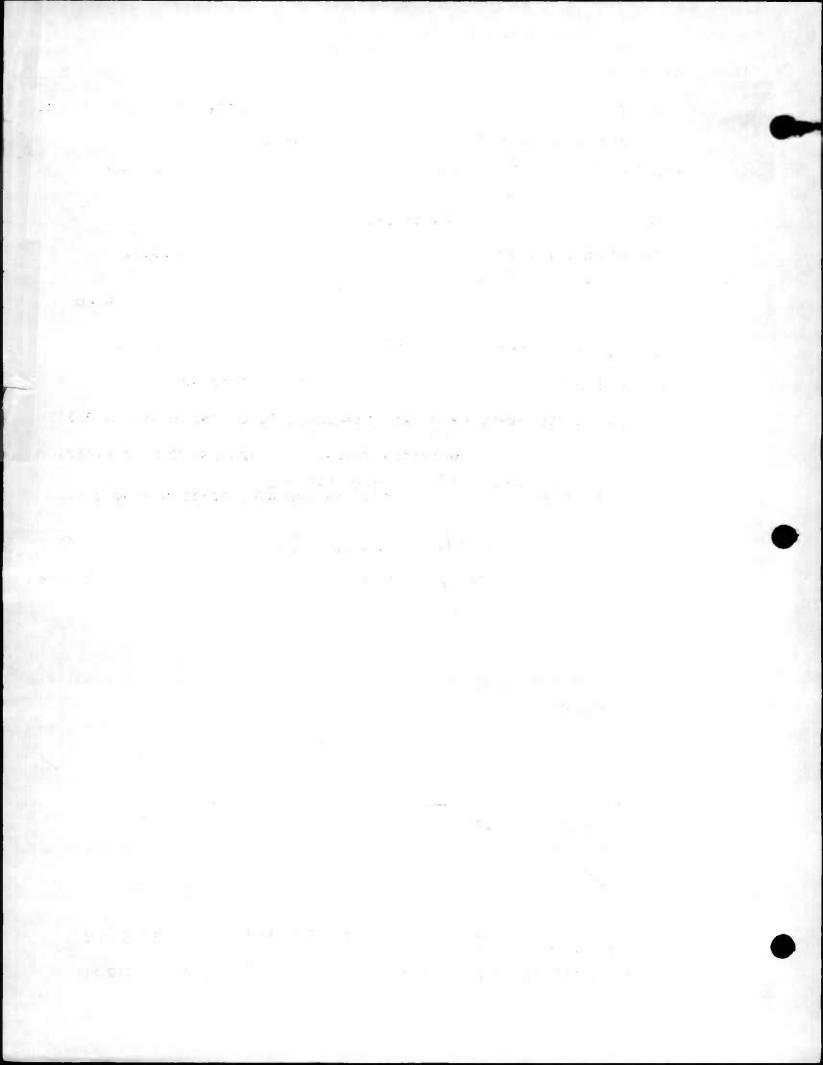
28b. Time of Injury

28a. Date of Injury (Month, Day Year)



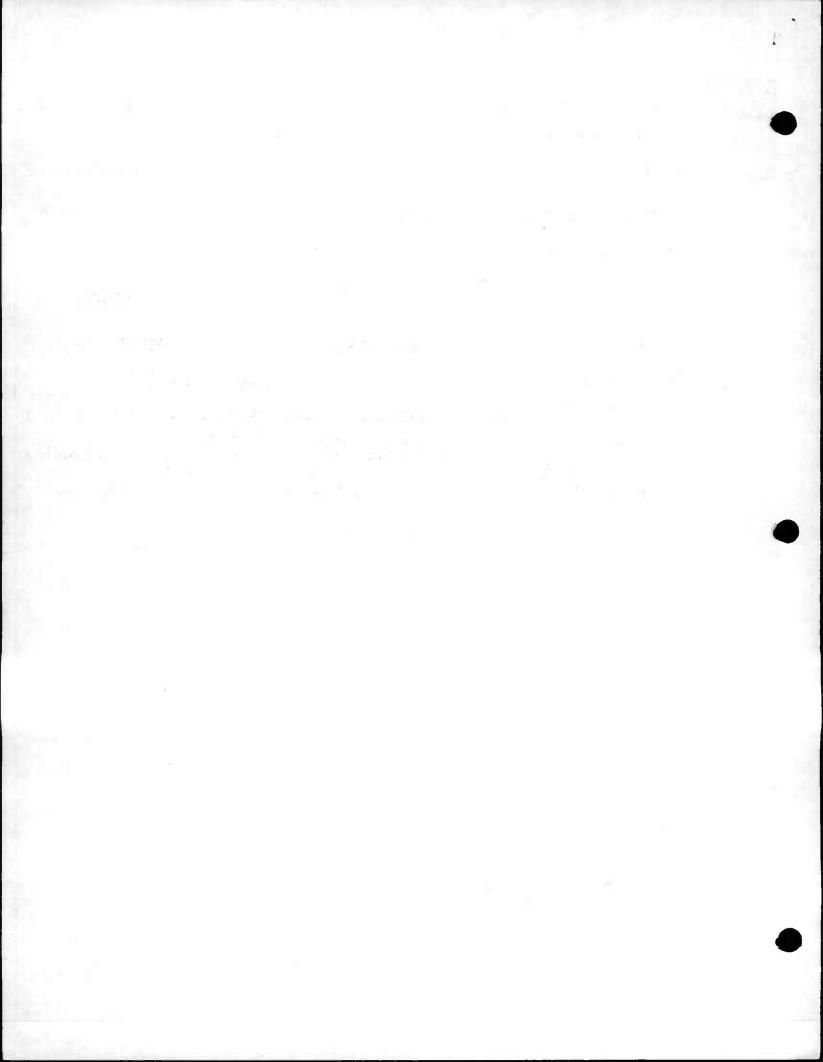
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Physici		MARIE ELIZABETH	MICHAEL				Month 7	Day 27 9	Year 98 10:1°
/Medic Examin		4e. Facility Name (If not institution, give				4b. City, Town, or I	Location of Deeth	4c. County	
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Director		313 38 SS83 11 Usual Residence of Decedent	□M 2 ⊠ F	66 Yrs.	Months Day	s Hours Min.	FS B. 4	1932	9. Birthplace (State of Country)
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or he	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorcad	12. Was Decadent E Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Year or Dates:	o 1:	3. Was Decedent of the Yes, specify Cu 1 ☐ Yes 2 🗚 N	f Hispanic Origin? (S uban, Mexican, Puert o <i>Specify:</i>	pecify Yes or No- o Rican, etc.)		e - American Indian, ck, White, etc.
natural,	P	15. Decedent's Edu	ucation	16a. De	cedent's Usual Occ	upation		16b. Kind of Bu	usiness/industry
than n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5-	(Gi	ve kind of work don . DO NOT use reti	ne during most of wor red)	rking		,
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Department of Health and Mental Hygiene, important: if item 27 is marked other than any injury or other traumatic event, the Mones.	To	LO MEART	VZN			List	A A	RMIT	Rool-
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of He r othe		20a. Method of Disposition	2111	20b. Place of Dis	position (Neme of		Date		City or Town, State
Department of Health Important: If item 27 any injury or other to		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Ex Ans F	rematory or other p	HAPST-	105 HIVE	FOREST	-11:11 Dag
Depertment Important: if any injury o	ŀ	21. Signature of Funeral Service bioerd		BILAI	22. Name and Add	ress of Facility	1998	1010231	HIT I IA
Departr Imports any inju		100	5 1	1	FLANKE	TRACE			
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- A -	1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	one cause on each line	the death. Do not e	inter the mode of o	ying, such as cardiac	or respiratory arre	est,	Approximate Interval Better Onset and I
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xaminer		Immediate Ceuse (Final disease or condition resulting in death)	Meta	127	- de	can a	ance	_	214
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🖂 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month Dey Yeer **Physician** W. RUTH MUELLER 28 1998 7:20 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** 7. Age (In yrs. lest birthday) Rosedale Baltimore Center tranklin Square Hours Min. 8. Date of Birth Mar. 12, 1923 If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Deys 1 ☐ M 2 💢 F 75 219-16-9301 Yrs **Director** Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Expresser must be notfied at Maryland Baltimore Baltimore County 1 ☐ Yes XX No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21220 12805 Eastern Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Bleck, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2XXNo Specify: Specify. ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nant of Haalth and Mantal Hygiene. nt: If Item 27 is marked other than " Elementery/Secondery (0-12) College (1-4or 5+) N/A Aberdeen Proving Ground 12th grade Clerk 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Clarence Monroe Wachob, Sr. Gladys Irene Yoemans 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2 s Department of Haalth ar Important: If Item 27 is any Injury or other trau P. O. Box 85 Chase, Maryland 21027 Mr. William C. Mueller 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 8-1-1998 Belair, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Belair Memorial Gardens 22. Name and Address of Facility
Lassahn Funeral Home 21. Signeture of Funerel Service Licensee 7401 Belair Rd. Baltimore, Md. 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical **Examiner** Due to (or es a consequence of) Physician/Medical Examiner Acidosis hours bolic Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury attending physiciar and for use as the burial man Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Cardiomyopa hemic that initieted events Due to (or es e consequenca of): resulting in death) Lest ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed been Bypass Graft page 2 s cartificata has 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifica completaly filled in by the funeral director. Be 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted. (Check only one)

29c. License number

Janar

Klin

-00

32. Registra s signaline

4 Ma Davidson

9000

30. Name and eddress of person who completed dause of death (Item 23e) (Type, Print)

-oh

29d. Date signed (Month, Dey, Year)

Drive

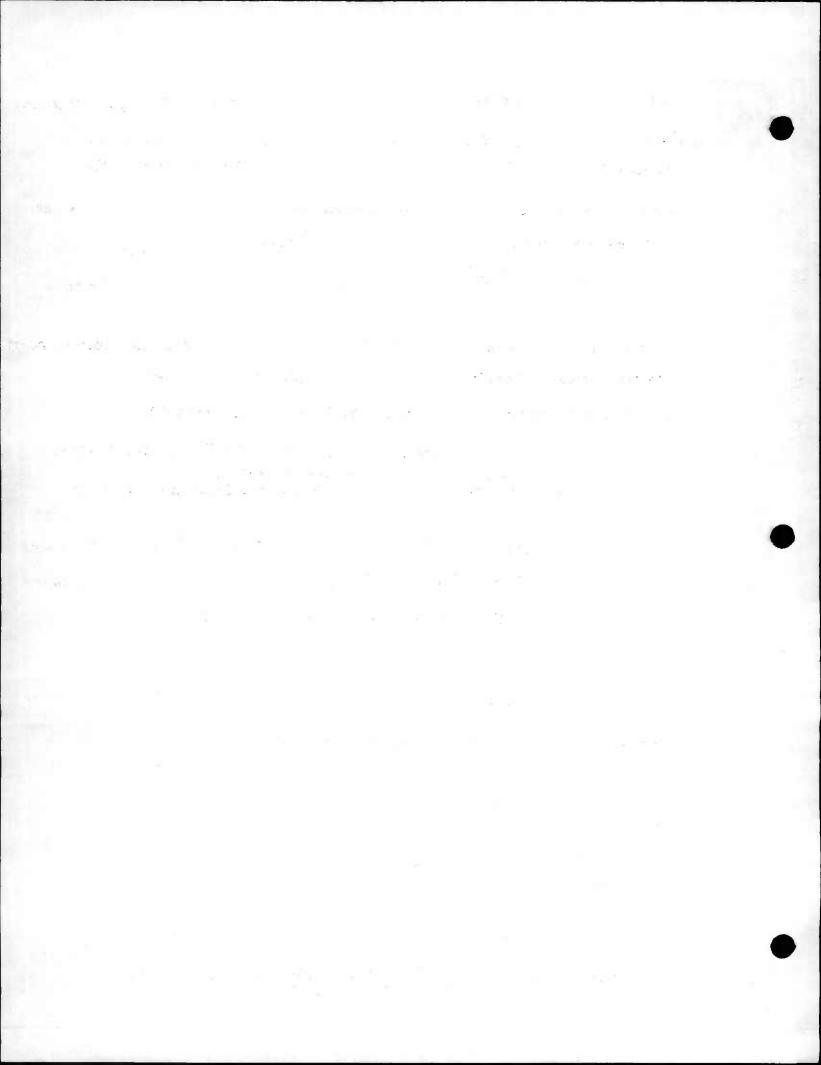
28.1

Saltimore

State Registrar 29b. Signature end title of certifier

31. Date filed (Month, Dey, Yeer)

John



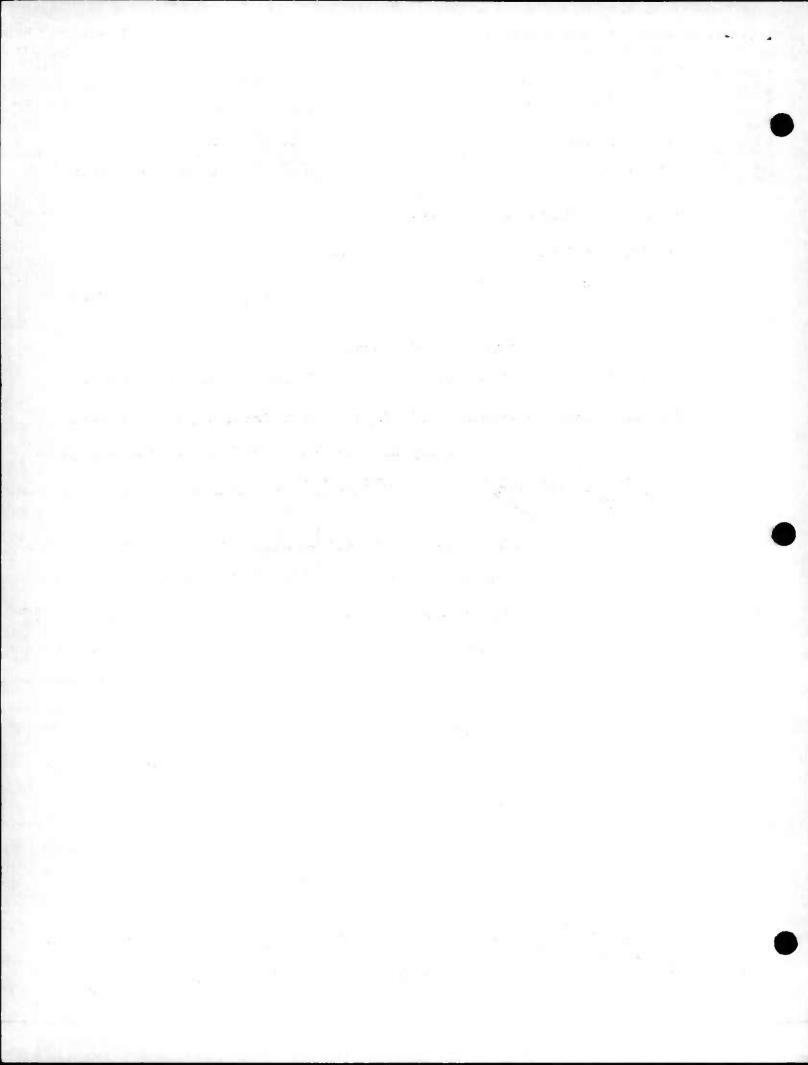
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JULY **Physician** ELIZABETH MINER 1:46 pm 26, 1998 /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore City | Baltinore creation | Baltinore creation | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore | Baltinore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** 1□M 2 F 56 217-40-5190 Director Maryland Usuel Rasidenca of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examples must be notified at 10d. Insida City Limits 1 ☐ Yes 2 No Director Maryland Baltimore County Essex 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1903 Cape May Road 21221 U.S.A. Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarlcan Indien, Bleck, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Years Coordinator Nursing 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Lawrence Sr. Furtaw. Matilda Pauline Roesner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Miner, Sr./Husband 1903 Cape May Road, Baltimore, Maryland 21221 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery 7/30/98 Baltimore, Maryland 21. Signature of Funeral Service Licenses John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Liet only on cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediata Causa (Final disease or condition resulting In deeth) SCLERODERMA RELATED CARDIOMYORATHY Examiner Due to (or es e consequança of): Examiner VALVULAR HEART OISEASE ARRYTHMIA Dua to (or as e consequenca of): Sequantially list conditions, if eny, leeding to immediate cause. Entar Underlying Causa (Disaese or Injury Box 68760. . PULMONARY HYPERTENSION. Physician/Medical thet initiated events resulting in deeth) Lest Due to (or as e consequence of): DIC 2441 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? · SEPSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? PNEUMOTHORAX. Completed 24a. Was an eutopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 12 Inpatiant 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Attending 5 Pending Invastigation 1 Naturel s efter deeth. I Director: Aft d in by the fur 1 Tyes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 THomicide Hospital or To the Hospital within 24 hours e To the Funeral Completely filled 12 Certifying Phyelcian: To the best of my knowledge, death occurred et tha tima, data and piece, end due to tha cause(s) and mannar as statad.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date end piece, end due to tha cause(s) end mennar stated. 29a, Certifian Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) P-11389 30. Neme and redorase of person who completed cause of death (Item 23a) (Type, Print) 6935 DONACHIE Rd App G, BALTIMORE MD GILBERT ZOGHBI 32. Registrar's Signature State una Davidson-Randelle

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

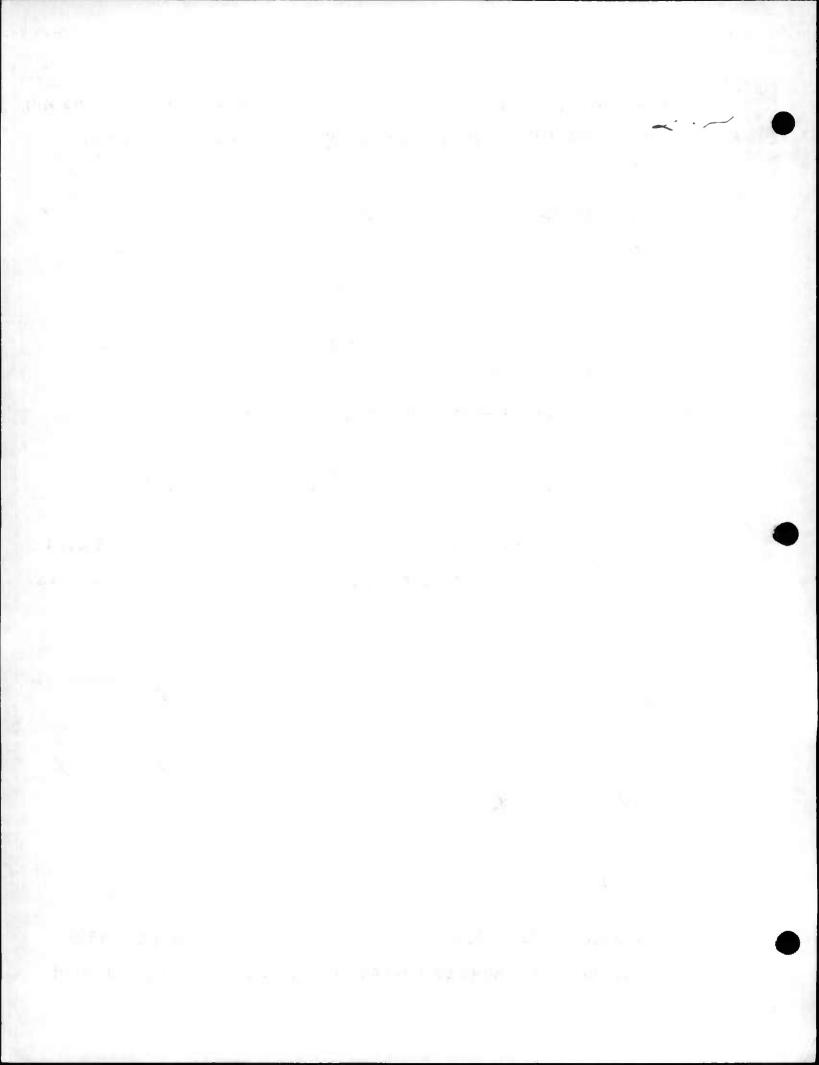
Certificate of Death

23389

	·		1. Decedent's Nam	e (First, Middle, La	st)						2. Date of D		Wi	3. Time of Deeth
	Physic /Medi		ROSE	NOVA	KOSKI						JULY	24	1998	1015 AM
	Exami			If not Institution, giv	e street and number,					b. City, Town,	or Location of Dee	th 4c. Cour	nty of Death	
1			JOHNS		US BAYY	ILEM	MEDI				MORE	BA	LTIM	ORE
	Funeral		5. Social Security N 213-14-		Sex 7. Ag	ge (in yrs. las		If Under Months	1 Year Days	If Under 24 H	in. (Month, D	ay, Year)	9. Birth	place (State or Foreign intry)
	Director		Usuel Residence o			95	Yrs.				9/11	1/02		RYLAND
	dand		10a. State	10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
	Man Man	to	MD	BALT	IMORE			BAL	TIM	ORE				1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Nu	mber				10f. Zip	Code			10g. Citizen o	of What Cou	intry?
	th will	al	1046	OLD NORT	THPOINT	ROAD			21	222		11	S.A.	
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces		13. W	/as Deced Yes, spec	lent of H	ispanic Origin? n. Mexicen, Pu	(Specify Yes or Nerto Ricen, etc.)	10- 14. R	lace - Ameri	icen Indian,
20	s afte	by F	1 ☐ Never Marr 3 ☑ Widowed	ied 2 Married	1 ☐ Yes 2 🖪 If Yes, Give	No		☐ Yes 2		Specify:		Spec		
5-0020	72 hours after death with the Maryland natural', or Nems 23a or 28s-1 show disal Examinet must be notlined at		2 Mar Andomed	15. Decedent's Ed	Year or Dates:		16e. Deced	net's Have	1 Occurs	ation .				WHITE
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Baltimore,	pemit. Pag Department Important: II any Injury o		21. Signature of Fu	neral Service Licer	IS 00 €		22.	Name and ACZ	Addres OROV	SSKI F	UNERAL	HOME I	.A.	
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3	Physician /Medical		Immediate Cause	'Final	0								1	Onset end Deeth
	Examiner	Ш	Immediate Cause (Final disease or condition resulting in death) e. Pneumonia										3 weeks	
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376		lical	Cause (Disease or that initiated events resulting in death)		C	Due to (or a	s a consequ	ence of):						
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Box	ath o	clan/Med			u								!	
			Part II. Other algnif	icant conditions o	ontributing to death b	ut not resulti	ing In the un	derlying ce	euse giv	en in Part I.	23b. Dlo	tobacco uae	ontribute t	to the cause of death?
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Ö	been shou	Completed									per	formed?	a' C	valleble prior to ompletion of cause
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ta	certificate	ပိ	25. Was cese refer	red to medical						00 DI 10		Yes 2 No	1	☐ Yes 200 No
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0	는 문학	n: T	27. Menner of Deat	h	28a. Date of Inju	iry 2	8b. Time of		Bc. Injury Work			how injury occ		ry)
Ö	ttending I death. ctor: After y the funer	atio	1 Naturel 2 ☐ Accident	5 Pending investigation	(Month, Da	y rear)	Injury	M		Yes 2□No				
Division	i or Atten after deat Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	ury - At hom c. (Specify)	e, farm, stre	et, factory	, office			(Street and Nul	mber or Rur	ral Route Number,
Ö	rs afte	Çe			ounding, or	o. (opodity)					Only of the	own, oraco,		
	tospi 4 hou funer ely fil	edical	29a. Certifier (Check only	Certifying Phy	ysician: To the best niner: On the basis o	of my knowle	edge, death	occurred a	at the tim	e, dete end pla	ice, and due to the	cause(s) end	menner as	stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Med	one)		and manner st	ated.					1			
	5 ¥ ₹ §	-	29b. Signature end	and or certifier	the St	200	ID			number		29d. Date sig	iiea (Month,	LOIG C
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DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Physician OMEVER ul /Medical 4a Fecility Name (If hot institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Year 6. Date of Birth (Month, Day, 9. Birthplece (State or Foreign Country)
Maky and 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□ F G Yes Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avant, the Medical Examinar must be notified at once. 1 ☐ Yes 2 No Director Maluland MONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White ò Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) egui Omen! DUSINUSS Elementary/Secondary (0-12) College (1-4or 5+) dures 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 10 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, Stete, Zip Code) 20a. Method of Disposition imonium 20b. Place of Disposition (Name of cemetery, cremetory or other place) July 28 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed 22. Name and Address of Fecility varis Approximate Intervel Between Onset and Deetl 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical CARDIO-PULMONARY INSUFFICIENC Examiner Due to (or es a consequence of): Physician/Medical Examiner 6E Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Records, P.O. Box 68760, The law requires that the death certificals by Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? cata has been signed by the page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown DECADES 11 2 24b. Were eutopsy findings eveilable prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No certificata Division of Vitai To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a, Certifier 29b. Signature and title of conti 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Day, Year)

Gandall.

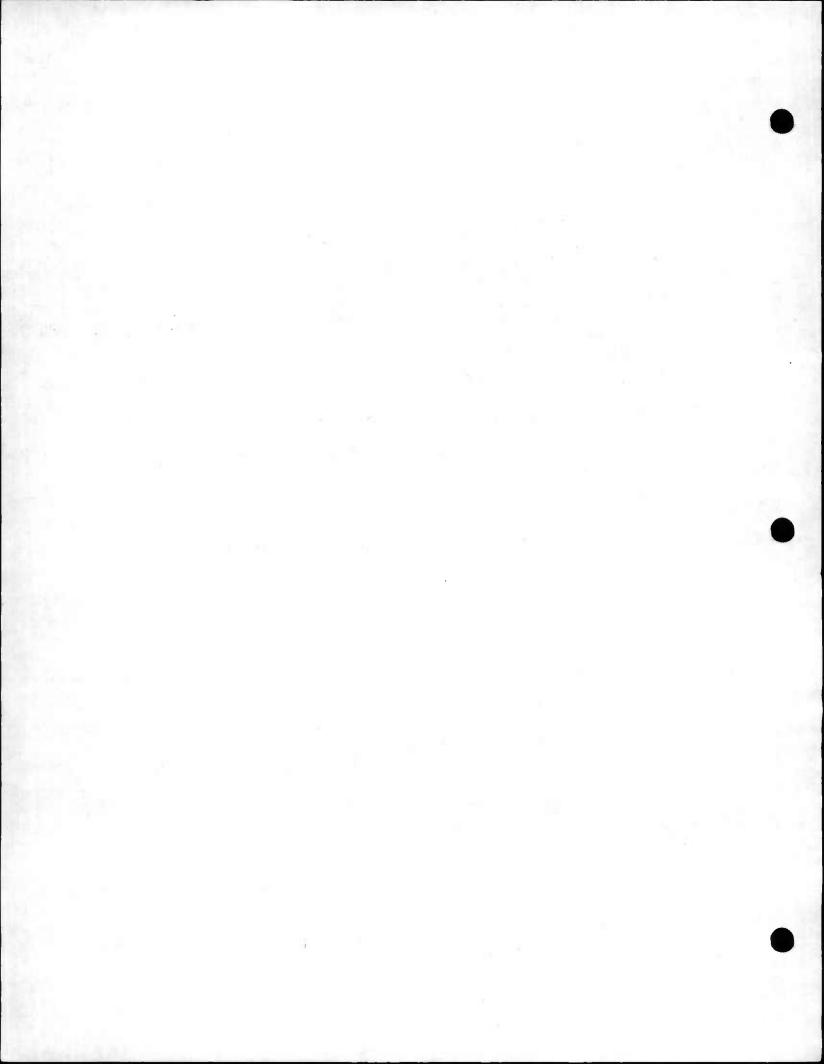
7-28-98

1112

who completed cause of death (frem 23a) (Type, Print)

32. Registrar's Signeture

This Davidson



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

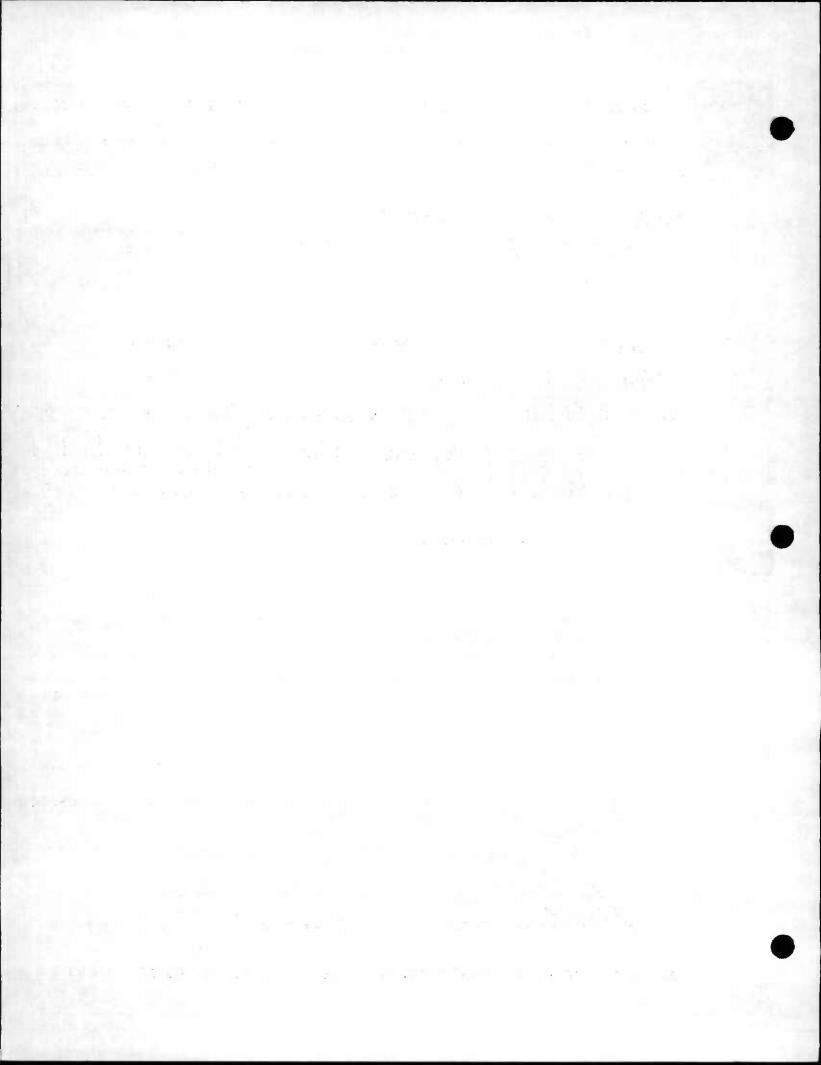
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yee **Physician** 30, 1998 8:20a.m. PARLETT DOLORES JULY /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner If Under 1 Year 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex (In yrs. last birthday) **Funeral** Days Min. 1 M 200 F Yrs Director allo 10 Usuat Residence of Decedent the Meryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Example, must be notified at 1 ☐ Yea 2 No Directo Maryland 10g. Citizen of What Country? 10e. Street end Numbe 10f. Zip Code Funeral de deeth 13. Was Decedent of Hispenic Origin? (Specify Yea or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Baca - American Indian. 11. Marital Status Black, White, etc filed within 72 hours efter 2 Married 1 Yes 2 No 1 ☐ Never Married 1 Yes 2 No Specify: WMIHE Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☐ Divorced or Dates: Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed withir ealth and Mental Hygiene. n 27 is marked other than Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RQUSON 0 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Peges 1 and 2 s
Depertment of Health an
Important: If Nem 27 is,
any injury or other trau Oa Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 3 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chapel of 8800 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical COLON CANCER Examiner Due to (or as e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Records, P.O. Box 68760, attending physi Due to (or as a consequenca of) the resulting In death) Last USB as Po Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 6 3 Probably 4 XUnknown 1 ☐ Yes 2 ☐ No signed b ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed peen has 2) No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA After this funeral Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 Yes 2 No Accident efter deet in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) a Hospital or A 124 hours efter Funeral Direct 4 Homleide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier edical pletely (Check onl) one) To the To the Comple 29d. Date signed (Month, Day, Year) 29b. Signature 29c. Lieense number Me-1550 3. 30 28 3: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 EDDIE NAKHUDA, 2300 DULANEY VALLEY RD., TIMONIUM, MD 31. Dete filed (Month, Day, Year)

JUL 3 1 1998 32. Registrar's Signature
what Dawydoon—Wandall State

Registrar

DHMH 16 Rev 6/95

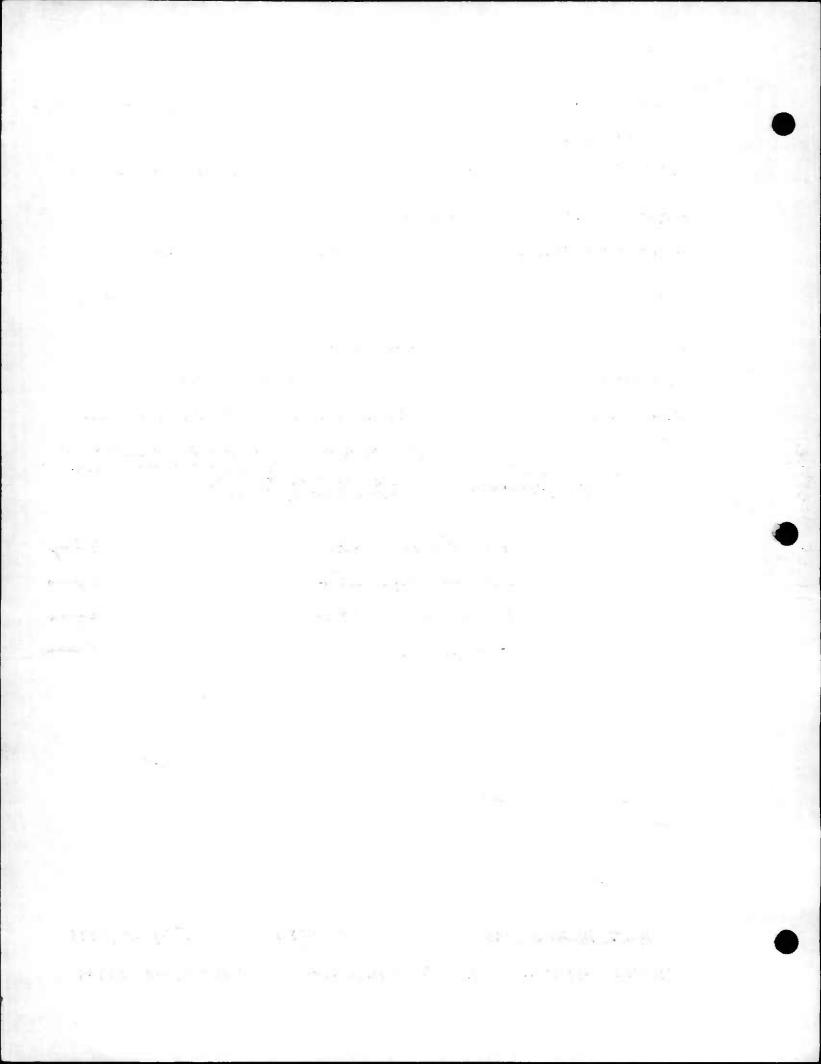


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State of Maryland / Department of Health and Mental Hygiene

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kamin		4e. Fecility Name (If not institut	ion, give	street end nu	m <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Deal	th 4		of Death		
		Union Hospit	al						Elkt	on			Ceil			
ral		5. Sociel Security Number	6. Se			s. lest birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	r)	9. Birthpl	lace (State o	r Foreig
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		Usual Residence of Decedent														
	_	10a. State 10b. Cour	ty		10c. C	City, Town or Lo	ocation							10	0d. Inside Ci	
	5	Maryland Ha	rfor	d	A	berdeen	l								1 🗆 Yes	2 X N
	Director	10e. Street and Number					10f. Zip (Code				10g. C	itizen of	Whet Coun	try?	
	a	322 South Park	Str	eet			2:	1001	1			U	SA			
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State of Maryland / Department of Health and Mental Hygiene TERRY PITTSNOGLE Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death JULY Day **Physician** 22, 1998 5:50 PM Terry Wayne Pittsnogle /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number)
POTOMAC RIVER UNDER R.R. BRIDGE 4c. County of Death Examiner CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 9. Birthplece (Stete or Foreign Country) West Virgini 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Days Hours 1₽M 2□ F Yrs. Director 44 232-90-3282 02-14-1954 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 1 XYes 2 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Virginia Avenue 21502 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes X No Specify: ğ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 disabled 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 87 and Menta Virginia E. Caton Alston C. Pittsnogle 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health and Important: If item 27 is n any injury or other traun 2004 Rome Drive, Martinsburg, WV 25401 Marsha A. Pittsnogle -sister Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removel from State 7-25-98 Martinsburg, WV Rosedale Crematory 4 Donetion 5 Other (Specify) 22. Name end Address of Facility Rosedale Funeral Chapel Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest,

Approximate Inches the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest,

Approximate Inches the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest,

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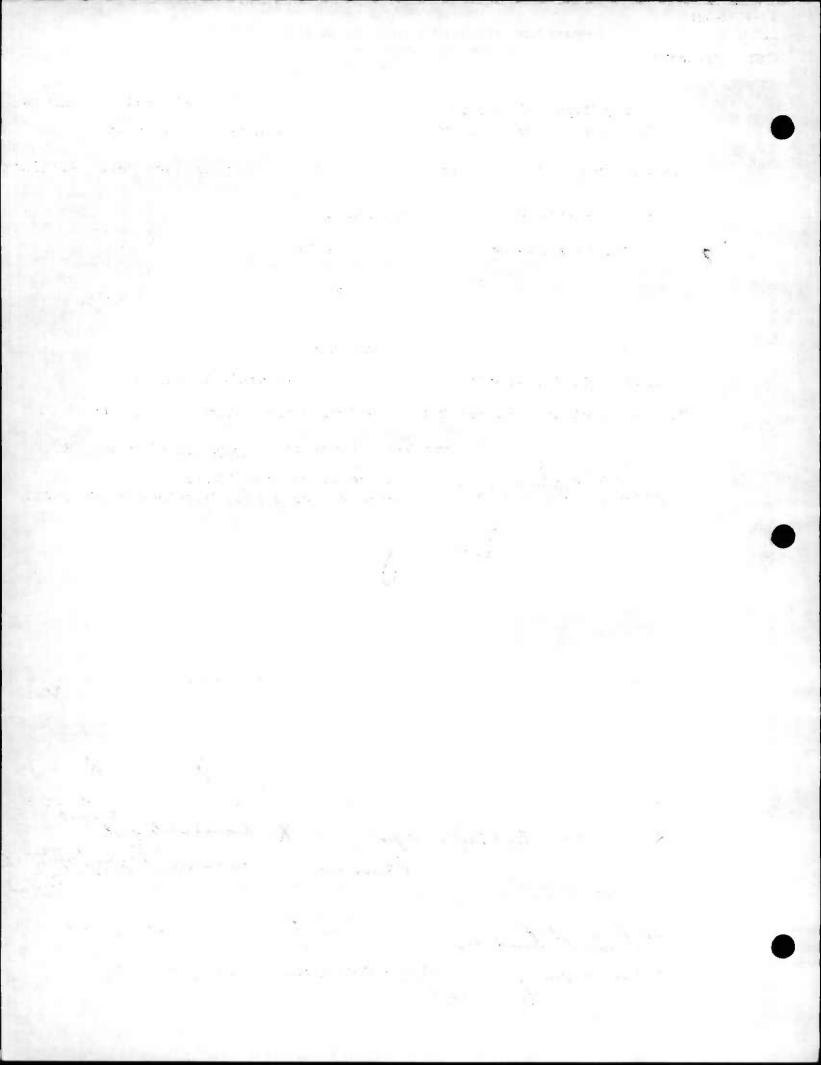
Approximate Inches the disease in the dise **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Vowmin Examiner Due to (or es a conse ienca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be deteched 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy 1 Yes 2 No 2□ No certificete Division of Vital Be 25. Was case referred to medical 26. Placa of Death (Check only one) aminer? XXYes 2□ No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) AT SCENE 2 28d. Describe how Injury occurred Subject funeral 28c. Injury et Work? 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of Certification: After 5 Pending investigation 28e. Place of Injury - At home, farm, street building, etc. (Specify) 1 Nature! Injury i or Attendin efter death. Director: Aft 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Nu streef, factory, office 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and menner as steted.

XX Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end manner stated. Hospital To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. Licanse number O.C.M.E JULY 23, 1998 ~~

d address of person who completed clude of death (Item 23e) (Type, Print) THEODORE Miken 111 Penn Street, Baltimore, Maryland 21201 1998 32. Registra & Signature

who Davidson-Randell

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Day Month **Physician** 24, Norman William Rehrio JULY 1998 2:40PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva straat and number) 4c. County of Deeth Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign Country) USA - Pa. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Hours 1X M 2□ F 171-01-8343 Director August 7, 1900 Usual Residanca of Decedant death with the Marylend 10d. Insida City Limits 10a. Stata 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours efter death with the Maryler ment of Health end Mentel Hygiene. ant: If item 27 is marked other then "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Experient must be northed 1 Yas 2 No Maryland Baltimore Directo Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 9206 Ravenwood Road USA Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - American Indian 11 Maritai Status Black, Whita, atc. 1X Yas 2 No If Yes, Giva Yaar or Datas: WW 1 1 Navar Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) Aerospace Engineer 12 Yrs. Bendix Company VOFMON N/A - 2 Yrs 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be James Franklin Rehrig Ellen Susan Scheller 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Sandra L. Dearholt Granddaughter 9206 Ravenwood Road, Baltimore, Maryland 21237 20b. Piace of Disposition (Nama of camatary, cramatory or other piece) 20c. Location - City or Town, Stata 20a, Mathod of Disposition permit. Pages Department of IImportant: If ite any injury or ot 1 € Buriai 2 Cremation 3 Ramoval from Stata Resurrection Acres Cemetery 7-27-98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facilit 21. Signature of Funeral Service Licanses Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 Approximata Interval Batween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Finel disaasa or condition resulting in death) unvocardi Examiner Dua to (or as a consaquanca of) days Physician/Medical Examiner nenmonia Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Records, P.O. Box 68760 Dua to (or as a consequance of) The law requires that the death certificate ettending | signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown þ 24b. Wara autopsy findings available prior to completion of causa of daeth? 24a. Was an autopsy Completed is certificate hes t director, page 2 s 1 Tas NO 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Wes casa rafarred to medical axaminar? 26. Placa of Daath (Chack only ona) Be Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Inpatient 1 Yas 2 No 2 ER/Outpatient 3 DOA this After this 28a. Data of Injury (Month, Day Yaar) 27. Menner of Death 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: 1 Alatural 5 Panding invastigation 1 Yas 2 No 2 Accidant Director: / 3 Suicida 6 Could not ba 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowladga, daath occurred at tha tima, deta end piece, end due to tha causa(s) and mannar as stated. 2 Medical Examiner: On the best of axaminetion end/or invastigation, in my opinion, deeth occurred at the time, date end piece, and due to the causa(s) and menner state. Medical 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatural d titia of cartifian

am 23a) (Type, Print)

1998 32. Register Signature

020688

Fairmount Are Towson, Md. 21286

State Registrar 30. Name and addrass of person with

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

_	g per FH G761 7/31/ I. Decedent's Neme (First, Middle			Cei	rtifica	te of I	Death	2. Dete of D	Reg. No.	600	3. Time of Death
n								Month	Dey	Yeer	
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r °											
5	1803 Chelse			lest birthday)	If Und	er 1 Year	Baltin If Under 24 H	rs. 8. Date of Bi	nth N		plece (State or Foreig
	230-03-5561	6. Sex 1 M 2□		76 Yrs.	Months	Deys	Hours M	n. (Month, D	ey, Year)		plece (Stete or Foreig intry) VA
ι	Jsuel Rasidenca of Decedent										
1	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1X Yes 2 □ No
_	MD NA		Ва	altimo							
1	Ioe. Street end Number				10f. Z	ip Code			10g. Citizen of	Whet Cou	intry?
_	1803 Chelsea	Road				2121			BLAC	43	U.S.A.
1	1. Mantal Status	Armed	ecedent Ever in U Forces?	,S. 13.	Wes Dec If Yes, sp	ecify Cuba	ispenic Origin? an, Mexican, Pu	(Specify Yes or N erto Rican, atc.)	0- 14. He	eck, White	Ican Indien, , etc.
	1 Never Merried 2 Marrie 3 □ Widowed 4 □ Divorced	If Yes,	es 20 No Give or Detas:		1 🗆 Yes	20 No	Specify:		Spec	ify: B1	ack
	15. Decedent		n Detas.	16a. Dece	dant's He	uel Occup	etion		16b. Kind of		
	(Specify only highes	t grade complete		(Give	kind of w	ork done a	during most of w	vorking	TOD. KING OF	Duali leasi li	ndustry
	Elementery/Secondery (0-12) Unknown		e (1-4or 5+)	CAL		oces			Dove	ee F	oods Inc
1	17. Fether's Neme (First, Middle, L	Last)		2 300		3003		eme (First, Middle			COGS THE
	George Edwar	- 7					Halon	Epps			
	19a. Informent's Neme/Ralationsh			19b. Meilir	ng Addre	ss (Street		Rurel Route Numi	ber, City or Tow	n, State, Zi	ip Code)
	Tommie L. Ry		fo	1803	Ch	else	a Rd.	Baltimo	ore Md	212	16
2	20a. Method of Disposition		20b.	Plece of Disponantery, cran				Data	20c. Location		
	1 Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Sp		JIII Stete					h /7 /00			
	21. Signeture of Funeral Servica L		WC	odlaw	2. Name	emer and Addre	ss of Fecility	8/1/98	Balti	nore	County,
	1 a bank	00.00	non) N	larc	h F/	H West				
_	23e. Pert1. Enter the disaase, or shock, or heart failure. List of	lle (DOIC					e, Balt		Md :	21215 Approximete
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disasas or injury c										
τ	Cause (Disaasa or injury that initiated events resulting in deeth) Lest	c	Due to (or es e consequenca of):								
		d									
F	art II. Other significant condition	ns contributing f	ntributing to death but not resulting			sulting in the underlying cause given in Pert I.			23b. Did tobacco use		to the cause of death
									Yes 2□ No	3 □ Pro	obably 4 Unknow
									s en eutopsy formed?	6	Vara autopsy findings velleble prior to completion of cause of deeth?
								10	Yes 2 No	1	☐Yes 2☐No
							26. Place of D	eeth (Check only			
2	25. Was case referred to medical			FR/Outpetier	nt 3 🗆 0	OCA Oth	OF:	Home 5 Pres		ther /Spec	eifv)
8	examiner?	Hospital:	Innatient 2	2 ER/Outpetient 3					how injury occ		,
	examiner? 1 Yes 2 No 27. Menner of Deeth	28e. De	eta of Injury	28b. Time o	f	Wor	42			ow injury occurred	
	examiner? 1 Yes 2 10	28e. Do			f M	28c. Injur Wor 1 🗆	k? Yes 2□No				
	examiner? 1 Yes 2 No 27. Menner of Deeth 1 Maturel 5 Pending	28e. Do (A	eta of Injury	28b. Time o Injury	M	10		28f. Location City or To	(Straet end Nur own, Stete)	n <i>ber or R</i> u	rel Route Number,
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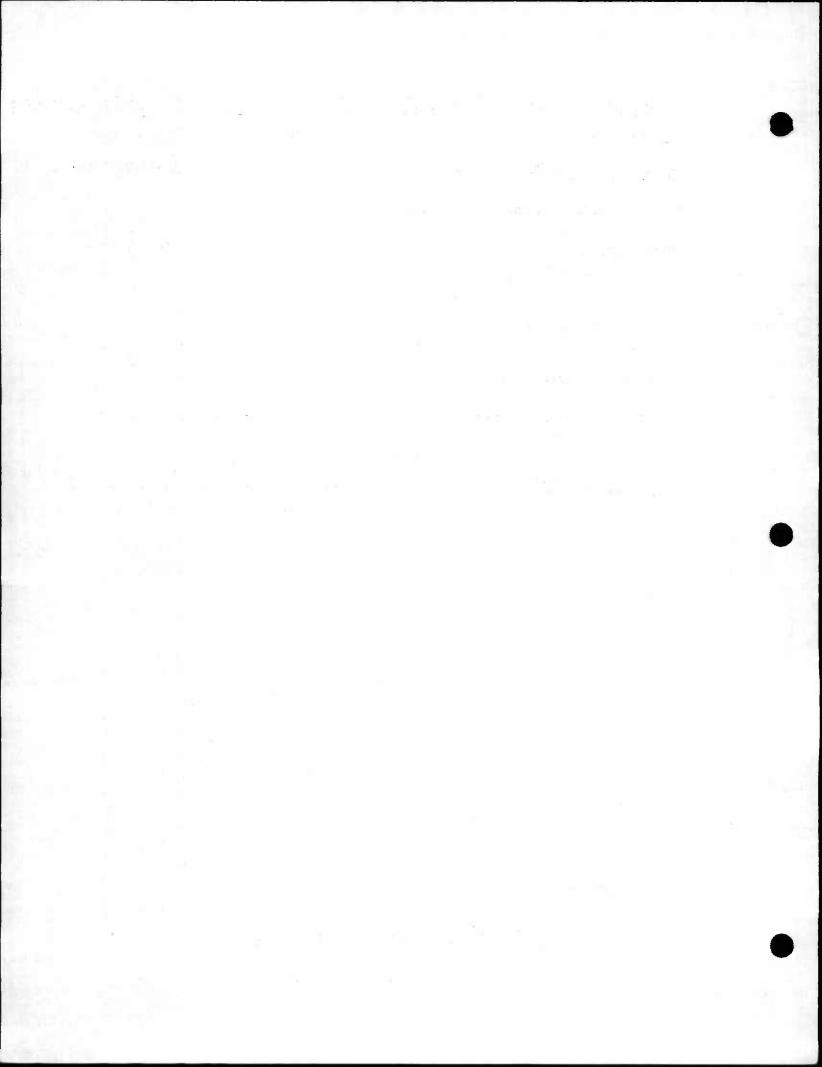
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State of Maryland / Department of Health and Mental Hygiene

					Certificate o	f Death		Reg. No.	9 60000
Physi	cian	Decedent's Neme (First, Middle, L.		01-1	O TO		2. Date of De		Year 3. Time of Deeth
/Med	dical	4a. Facility Neme (If not Institution, gi		OGER	S, JR	4b. City. Town	JULY, or Location of Deet	24 L	998 645 Al
Exam	uner	12413 Sandal La				Bowie			ce George's
Funera Directo			Sex. 7. Ago 10 M 2□ F	74 , Y	hdey) If Under 1 Yea Months Dey		Hrs. 8. Dete of Bi Min. (Month, D NOV • 2	year) 923	9. Birthplece (State or Foreign Washington D.C
e Maryland	ctor	10a. State 10b. County Maryland Prince	George's	10c. City, Town Bowie					10d. inside City Limits 1,2 Yes 2 □ No
ath with the 23a or 2	ral Director	10e. Street end Number 12413 Sandal Lan			10f. Zip Code 20715			10g. Citizan of United	Whet Country? States
Maryland 21215-UU2U d 2 should be filed within 72 hours after death with the Maryland th end Mentel Hygiene. 7 Is marked other than "natural", or items 23e or 28e-f show traumetic event, the Medical Examinet must be neatled	d by Funeral	11. Maritel Stetus 1 Never Merried 2 Merried 3 XWidowed 4 Divorced	12. Wes Decedent I Armed Forcas? 1 12 Yes 2 1 N If Yas, Giva Yeer or Detes:	lo	13. Wes Decedent of If Yes, specify Control of Image 21. In Yes 2		? (Specify Yes or No Puerto Rican, atc.)		ce - American Indien, lok, White, etc. White
d 21215-0020 filed within 72 hours aft Hygiene. ther than "natural", or out, the Medical Exami	Completed	15. Decedent's E (Specify only highest gi Elementery/Secondery (0-12) 1.2	ducation ada complatad) College (1-4or 5	+)	Decedent's Usuel Occ (Give kind of work don life. DO NOT use rati 11yst	upation le during most of red)	working		overnment
Maryland 2 d 2 should be filed the end Mentel Hygis T is marked other traumatic event, in	To Be	17. Fether's Neme (First, Middle, Las Robert H. Roger					Neme (First, Middle ine Dorri		ne)
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t. Page: tment of tant: If I		1 Buriel 2 CCremetion 3 [fy)	cemetery	crematory or other p	7		Waldorf	
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Physician /Medica Examine		23e. Payl 1. Entar the disease, shock, or haart failure. List only Immediate Cause (Final disease or condition resulting in deeth)	Small		Lung	Can			Approximele Interval Between Onset end Death 7 monTh 8
OX 68/60, certificate be executed ading physician end ase as the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	c	Due to (or es e co					
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director.	o Be	25. Wes case referred to medical examiner? 1 □ Yes 2 No	Hospitel:	nt 2 ER/Out	patient 3 DOA	28. Piece of Other: 4 Nursi	Deeth (Check only		her (Specify)
ding h. Afte funeral	Certification: T	27. Mennar of Death 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of injur (Month, Dey	y. 28b. T	me of 28c. in jury		28d. Describe	how Injury occur	
DIVISION Hospital or Attending 24 hours after death. Funeral Director: Afte		4 Homicide detarmined	building, etc	(Specify)	m, street, fectory, offic		City or To	wn, Stele)	ber or Rurel Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29e. Certifiar Certifying P	hysician: To the best of miner: On the basis of end menner sta	examinelion end	deeth occurred et the or investigetion, in my	time, date end p opinion, deeth o	elece, end due to the occurred et tha tima,	ceuse(s) end m data and place,	annar as steted. end due to the causa(s)
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		Cuser	W Cock	W M.	D	1635	4	TULY.	24,1998
		30. Name and address of person who	completed cause of da	seth (Item 23e) (I	Rd, A	mapali.	is, mo	2140	,
S	tate	31. Dete filed (Month, Dey, Year)	32 Begistre	r's Stoneture	Na) 1)	III SEP CIT	, , , ,	0170/	
Regis		JUL 3 1 1998	guille varido	ev-Novier					

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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 07-30-MARV 98 2039 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SECOURS HOSPITAL Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 29,1913 If Under 1 Months 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 KF 238-24-6459 South Carol Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland 10e. Street and Number N/A Baltimore 10f. Zip Code 10g, Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. 112 N. Wheeler 21223 Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes X No Specify: **¾** Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Seamstress 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Maggie Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Scott-son 112 N.Wheeler Ave Balto.Md.21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition *Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-5-98 Lansdowne, Maryland Mount Zion Cemetery 22. Name and Address of Facility Caple Funeral Service 21. Signaliza of Funeral Service I Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart feilure. List only one cause on each line. 5502 Winner Ave.Balto.Maryland 21215 of liver with metastesis Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequenca of): Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23s or 28s-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural; or Items 23s

of Health end Mentr

= 0 permit. Page Department of Important: if any injury or once.

Baltimore, Maryland 21215-0020

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Division of Vital

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Funeral

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Completed

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Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last þ Completed

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Sulcide

29a. Certifier

4 ☐ Homicide

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 25. Was cese referred to medical examiner?

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy

1 ☐ Yes 2/X No 1 Yes

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

107 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier H Macem M.D

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

Delphin st Bollimore MD ala HAEEM, 501 12 Ametical Speature Randson

Registrar

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Certification: To

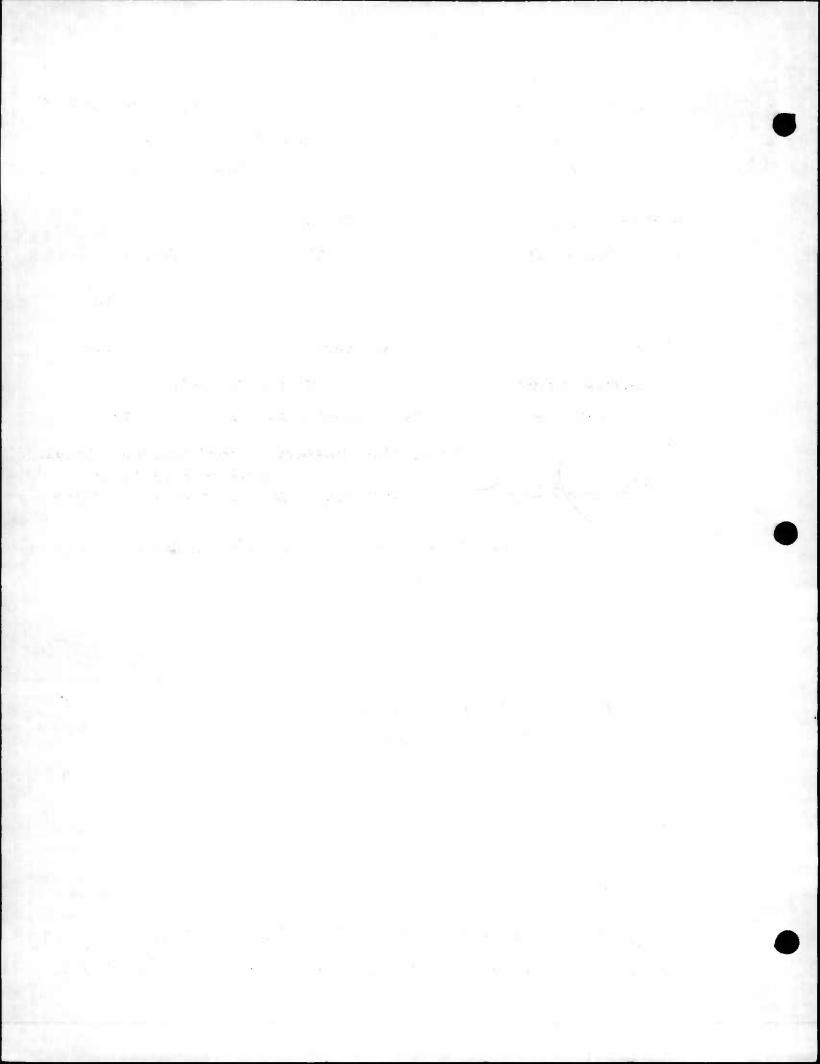
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/s efter dea. rai Director: After b.

To the Hospital of within 24 hours of To the Funeral Discompletely filled in

or Attending

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23398 Item#4c per Phy G762 8/3/98 I Item#26 per Phy G761 7/31/98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **SCURRY** 26 LILLIAN 1998 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel **PASADENA** MAGOTHY BEACH ROAD 8. Dete of Birth (Month, Dey, If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 M F Min 218-22-4526 Yrs. Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 No MARYLAND PASADENA UNKNOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 63 MAGOTH BEACH ROAD 21122 USA, 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ZYRS ELECTRONIC ASSEMBLER WESTING HOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) JACKSON SR. WILLIAM BERTIE ANDREW HOWARD 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 68 MAGOTHY BEACH RD. PASADENA, MD 2/122
pe of Disposition (Name of Dete 20c. Location - City or Town, State ILLIAN D. (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State E CEMETERY 7-31-98 CROWNSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lice JOSEPH H. BROWN JR. FUNERAL HOME, P.A. FULTON AVENUE, BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediete Cause (Finel disease or condition resulting in death) . Oat cell caranoma Due to (or as e consequenca of):

Physician /Medical Examiner Physician/Medical Examiner

the burial-transit and

Completed by

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Certification:

Medical

Hospital or Attending Physician: The law requires that the death certificete be executed

this certificate

To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Funeral Director

Completed by

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examine must be notified at once.

Baltimore, Maryland 21215-0020

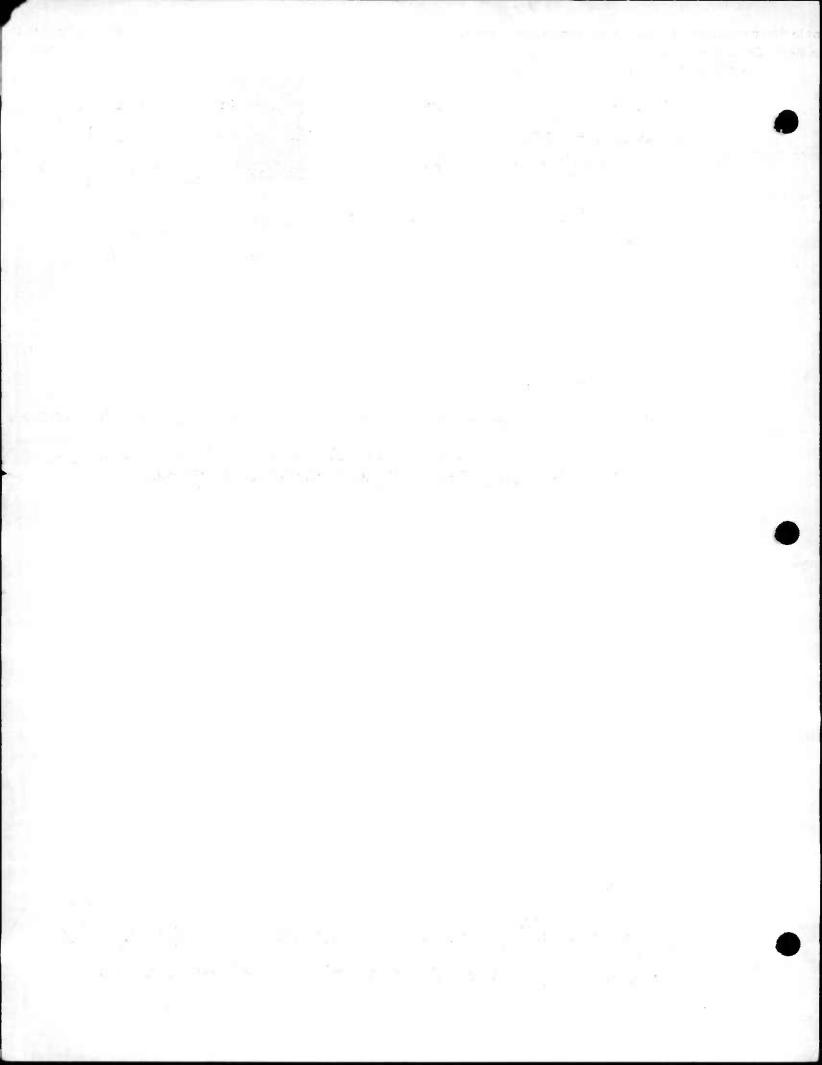
hth, Day, Year)

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	ascitis_	or es e consequence	ot):		
that initiated events 'resulting in death) Lest	Due to (or as e consequence	of):		
Part II. Other eignificant conditions cont	ributing to death but not re-	sulting in the underlyi	ng cause given in Part I.	23b. Did tobacco use	contribute to the cause of death?
This hory of	hyperthys	Jord		1 □ Yes 2 □ N	(4
Fristry g	hyprits	nsion		24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause ot deeth?
This forms of	Supra ve	ufricula	v tacher Car.	1 □ Yes 2 N	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of	Deeth (Check only one)	
1 Yes 2 No	ospital:	ETVOutpatient 3	DOA Other: 4 Nursin	g Home 5 Residenca 6	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injury at Work?	28d. Describe how injury oc	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, tad	ctory, offica	28f. Location (Street and No City or Town, State)	mber or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Physic Certifying Phy	cian: To the best of my known: On the basis of examination and manner stated.	owiedge, death occur ation end/or investiga	red at the time, date and pl tion, in my opinion, death o	ace, and due to the ceuse(s) and ccurred at the time, date and place	manner as stated. ce, end due to the cause(s)
29b. Signature and title of certifier ARM 5	Ruggent	UD	29c. License number D18446	July July	gned (Month, Day, Year) 28, 1998
30. Name and address of person who con GB Ruppus f MID 31. Date tiled (Month, Day, Year)	npleted cause of deeth (Itel 36/ S.f.	m 23a) (Type, Print)	P. #411 1	Bathimore M	D 21202.

State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23399 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:00 AM Toli RUTH MAY SPENCER 30 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE SAINT AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 KF Yrs 219-50-5760 84 Director APRIL 3,1914 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits Show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla the parafrinent of Health and Mental Hygiene. Important: If item 23 is marked other than "natural", or items 23e or 28e-1 show any highty or other traumatic event, its Medical Examiner must be notified. 1 ☐ Yes 2X No Director MARYLAND BALITMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21227 2824 ILLINOIS AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: by WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Bustness/Industry Eiementery/Secondery (0-12) Coilege (1-4or 5+) HOMEMAKER DOMESTIC 7TH GRADE 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be P PAULINE BERGMAN OTTO MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) ROBERT W. SPENCER (SON) 2824 ILLINOIS AVENUE - BALTIMORE, MARYLAND 21227 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK 8/1/98 Service Licensee HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229 23h Partt. End the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, a neart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final . Brain stem Cove bro vascular Accident week disease or condition resulting to deeth) Examiner Due to (or as a consequenca of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/M Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed D808 2 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Wes case referred to medical Be 26. Place of Death (Chack only ona) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 報 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Neturei 2 Accident 5 Pending i or Attendin after death. Director: At 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Spacify) 4 Homicide hours 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 25 To the To the 29d. Date stgned (Month, Day, Year) 29b. Signature and title of cartifier Haukose, MD 29c. Licanse number 30,1998 046704 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Yaar) 32. R

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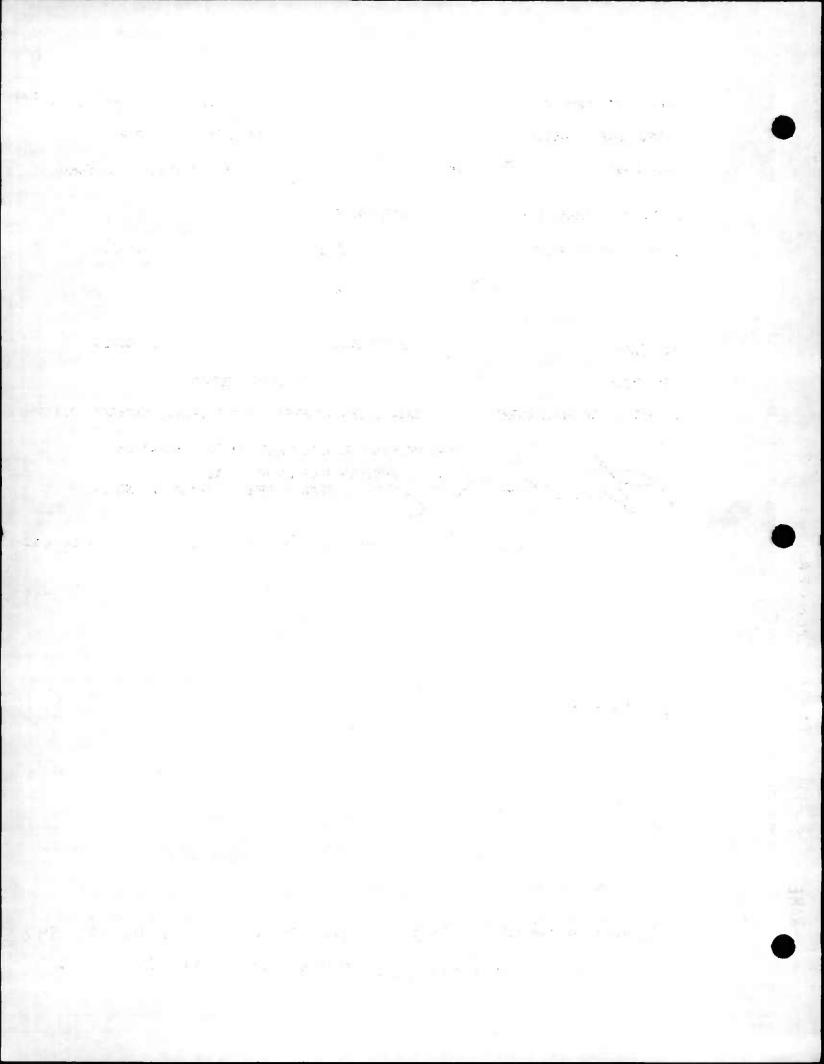
32. Registrar's Signature

Julia Davidson-Handale

ST

AGNES HOSPITAL

SPENCE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3400 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev Yeer Month 28, 1998 CLARA AGNES SMITH JULY 1:13 PM 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 921 RYAN STREET BALTIMORE N/A If Under 1 Year | if Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Deys Months Hours 1 M 2 XF Yrs. 215-80-7997 JULY 10,1914 MARYLAND Usuel Rasidence of Decedant 10e. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Mas 2 No MARYLAND BALTIMORE N/A 10f. Zip Code 10g. Citizan of Whet Country? 10e. Street end Number 21223 U.S.A. 921 RYAN STREET 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yas 2 No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grade completed) 16e. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) 7TH GRADE HOMEMAKER DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SARAH L. WAGNER JOSEPH GRAHAM 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) 921 RYAN STREET - BALTIMORE, MARYLAND 21223 GERALD SMITH 20b. Plece of Disposition (Name of cemetery, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Char (Specify) 8/1/98 LOUDON PARK CEMETERY BALTIMORE 21. Signature of Fun Service Licenses HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 not sever the mode of dying, such as cardiac or respiretory arrast, Approximete Interval Betwean Onset and Deeth art1. Ent he disease, or com in failure. List only Immediata Causa (Final diseese or condition resulting In deeth) saguanda of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Part II. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings evailable prior to complation of cause of deeth? 24e. Wes en eutopsy parformad? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haaith and Mentai Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any highry or other traumatic event; the Medical Examinat must be notified and appropried.

Baltimore, Maryland 21215-0020

signed by the a should I

Physician/Medical Examiner by Completed Be 1º

is certificate has to director, page 2 s Hospital or Attending Physician: this Aftar death.

The law requires that the death cert

Division of Vital Records, P.O. Box

Certification:

edical

within 24 hours after death To the Funeral Director: completely filled in by the To the

25. Was case referred to medical examiner? 1 Yas 2 No 27. Maryler of Deeth

29b. Signeture end title of certifier

5 Panding Invastigation 1 Naturel 2 Accident 3 Suicide 4 \ Homicide

6 Could not be datermined

28e. Data of Injury (Month, Day Year) Injury

28c. fnjury et Work? 28b. Time of

28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

26. Piece of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end dua to the ceuse(s) end menner steted.

29c. License number

29d. Date signed (Month, Day, Year)

21223

who completed dause of deeth (Item 23e) (Type, Print) 30. Name and edd ess of person

ETMO/W. GAYOSO - 1600 WILKENS AVENUE - BALTIMORE, MARYLAND

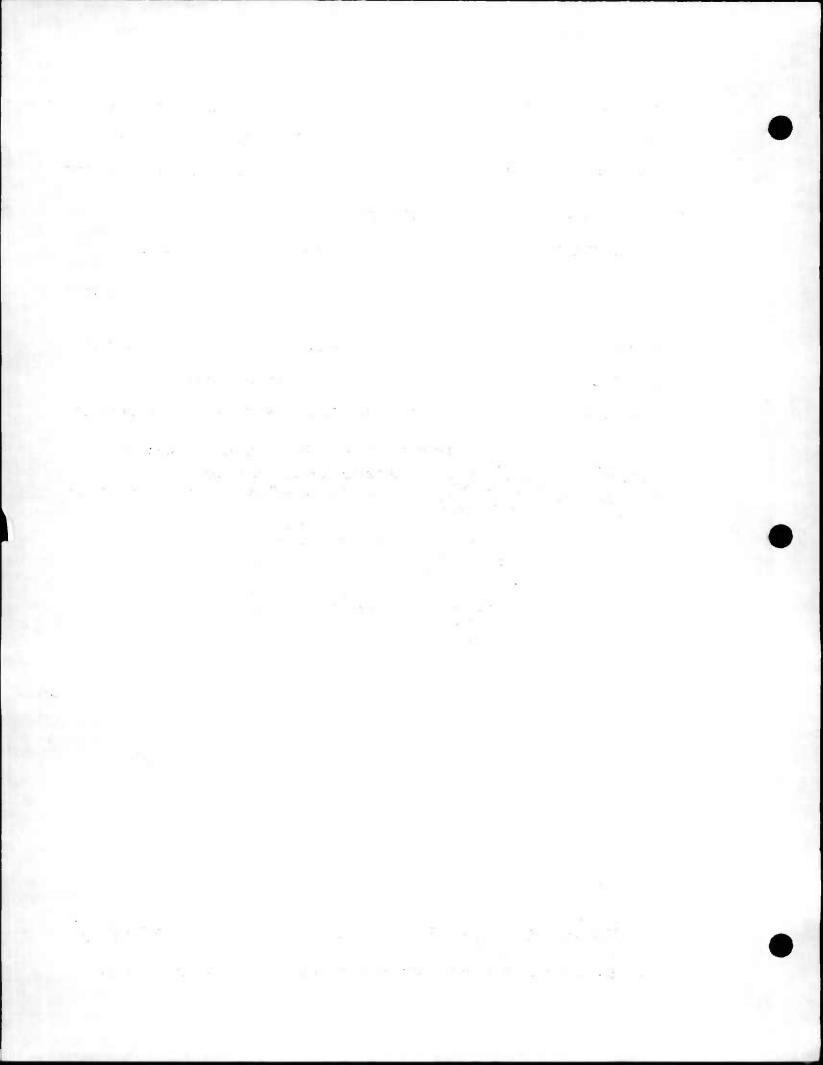
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29a, Cartifiar



DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Item#26 per Phy g761 7/31/98 EW 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 40 vilue 26 a.m 1998 Sean Sterling 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death 2902 Baltimore DOWERS 7. Aga (In yrs. last birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Date of Birth (Month, Dey, Yaar) | NOU. 5 | QQ7 AUENUE NA 5. Social Security Number 9. Birthplace (State or Foreign 10 M 20 F 216-92-9274 md Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits md 1 19195 2 No altimore NA 10g. Citizan of What Country? 10e. Street and Number AZU 2120 DWERS 2902 12. Was Dacedant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Dates: 1 Nevar Merriad 2 ☐ Married 1 Yas 2 No Specify: Specify 3 Widowed 4 Divorced NOC 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Eiamantary/Secondary (0-12) Coilaga (1-4or 5+) ollege NA 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fether's Neme (First, Middle, Last) ARNold MINNIE 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Nymber, City or Town, Stata, Zip Coda) 2902 BOWERS - Mother Dalto. Md. MINNIESterl INA ve 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 7-30-98 4 ☐ Donation 5 ☐ Other (Specify) 22 Nama and Address of Facility Home-West, The m of Funeral Sarvice Licensea 4300 Wabas 23a Part. Enter the unless, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock or heart the max. List only one cause on each line. Approximata Interval Batween Onsat and Daath immediata Cause (Finel disaasa or condition resulting in death) VENTRICULAR ARRKYTHMIA HYPERTROPHY ENTRICULAR Dua to (or as a consequenca of): PERTENSION Dua to (or as a consaquanca of): 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Wera autopsy findings avellebla prior to complation of causa of daath? 24a. Wes en autopsy performed? 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yas 26. Placa of Daath (Chack only one)

Physician /Medical Examiner

the burial-transit

signed b

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certificate hes

funaral

filled in by

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: Attar this certifica

To the To the To the

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Completed

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Certification:

Medicai complataly

Physician

/Medical

Examiner

Director

Funeral

by

Funeral

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at

with the Maryland

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permit. Pages 1 and 2 should be filed within 72 hours efter deet Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trauments.

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Diseasa or Injury that Initiatad evants rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END-STAGE RENAL DISEASE

25. Was casa rafarrad to medical 1 ☐ Yas 2 No

27. Mannar of Death 1 Natural

2 Accident 3 Suicida 4 \ Homicide

JONATH AN

5 Panding invastigation 6 Could not be determined

Hospitel: 1 | Inpatiant | 100 | Inpatiant | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 28e. Dete of injury (Month, Day Year)

28b. Tima of injury

1 ☐ Yas 28a. Plece of Injury - At home, farm, straet, factory, office building, atc. (Spacify)

28c. Injury at Work? 2 🗆 No

Othar: 4 ☐ Nursing Homa 5 ♣ Assidance 6 ☐ Othar (Specify) 28d. Dascriba how injury occurred

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata)

SuiTE 344

29a. Cartifiar (Check only one) 15 Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha cause(s) and mennar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and menner stated. 29c. Licensa number

29b. Signature and itla of certifier

30. Name and addrass of person who complated causa of daath (Itam 23e) (Type, Print)

29d. Date signed (Month, Day, Year)

BALTIMORE

MD 212

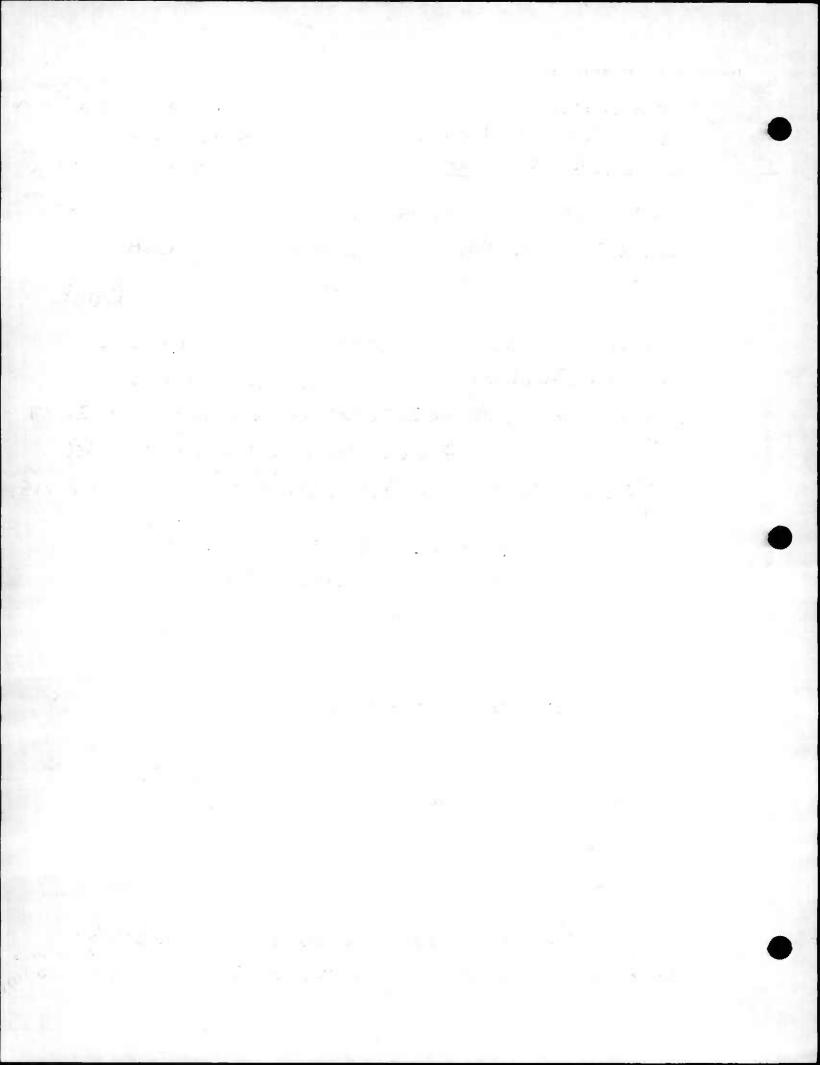
State Registrar 31. Data filad (Month, Pay, Year) 1 1998

PHILIPSON 2 HAMILL RD. 32. Registrars Signature

Sulia Davidson-Aandale

DHMH 16 Rev 6/95

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Please Type or Print in Biack indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year SCHONHOFF 6:05 PM 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number, 4c. County of Death Bon Baltimore Secours Hosp, tay NA Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) 5. Social Security Number 6. Sex 1 ■ M 2 F 217-32-892 8 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 10 Tes 2 □ No NA 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number U. 5.A 12. Was Decedent Ever in U.S. Armed Forcas? 3426 2/2/7 Terrace 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Private Homes Elamantary/Secondary (0-12) College (1-4or 5+) 12th grade NA omestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumeme) hartes Patterson Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Balto, md 21216 - Brother atterson lam 20b. Place of Disposition (Neme of cometary, crametory or other p 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 7-31-98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wabash 300 Balto, red ZIZIS Arenne 23a. Part 1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death ENCE PHALOPATHY tmmediata Causa (Final disease or condition resulting in death) us to (or as a consequence of): Due to (or as e consequence of): 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

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Completed

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To

Physician/Medical Examiner

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Completed

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Certification:

Medical

Funeral

Director

with the Meryland

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylen Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f show any Injury or other treumatic event, the Modical Examiner must be northed at ence.

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

The law requires that the death certificate be

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certificate has

After this Director: After this in by the funeral

Funeral D

To the Hospi within 24 hou To the Funer (completely file

director.

Hospital or Attending Physician: 24 hours effer deeth.

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ERTENSION 26. Place of Death (Check only ona)

24a. Was an autopsy

1 Yas 2 No

24b. Were autopsy findings available prior to completion of ceuse of death?

1 ☐ Yas 2 ☐ No

25.	Was casa	rafarrad	to	medical
	examiner?			
	1 Yes	2 No		

27. Menner of Death

5 Pending Investigation

1 Inpatient 28a. Data of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29a. Cartifiai

1 (Natural 2 Accident

3 Suicide

4 ☐ Homleida

to Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and sets of certifier

6 Could not be determined

29c. License number

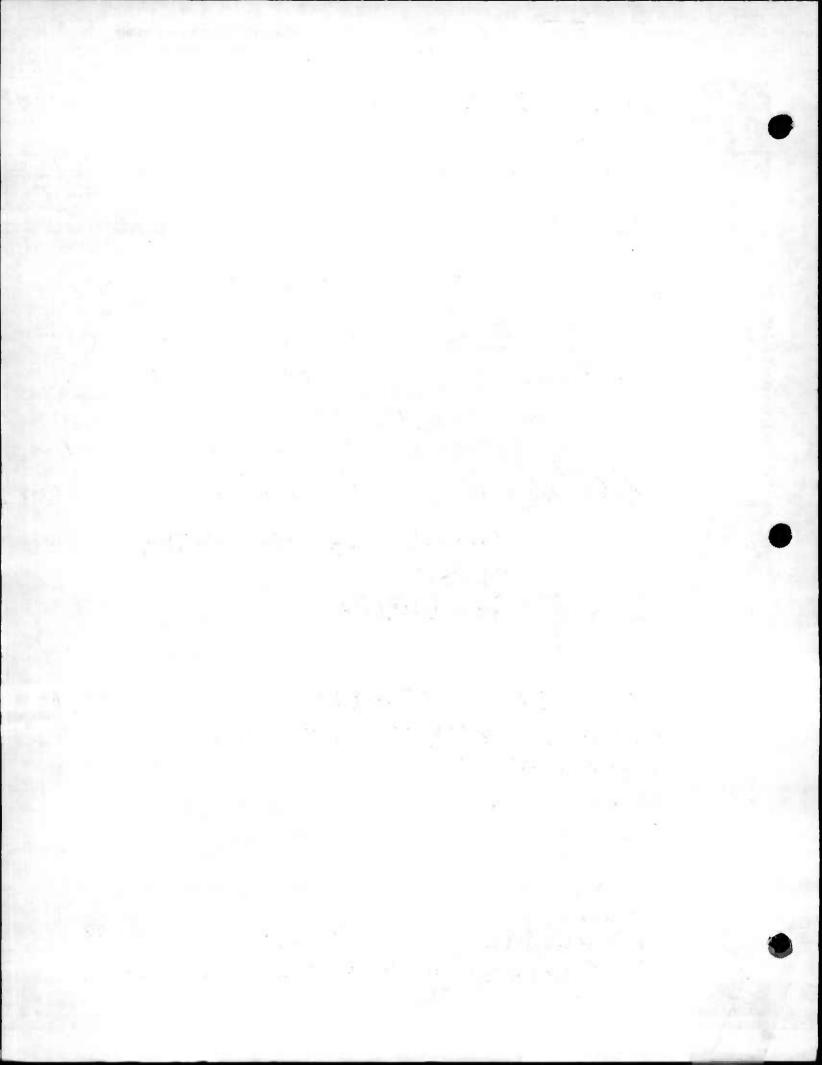
1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Dey, Year) 7-28-98

erson who completed cause of death (Item 23a) (Type, Print)

BALT, 14/1 2/223 940 31. Data filed (Month, Day, Year) 3

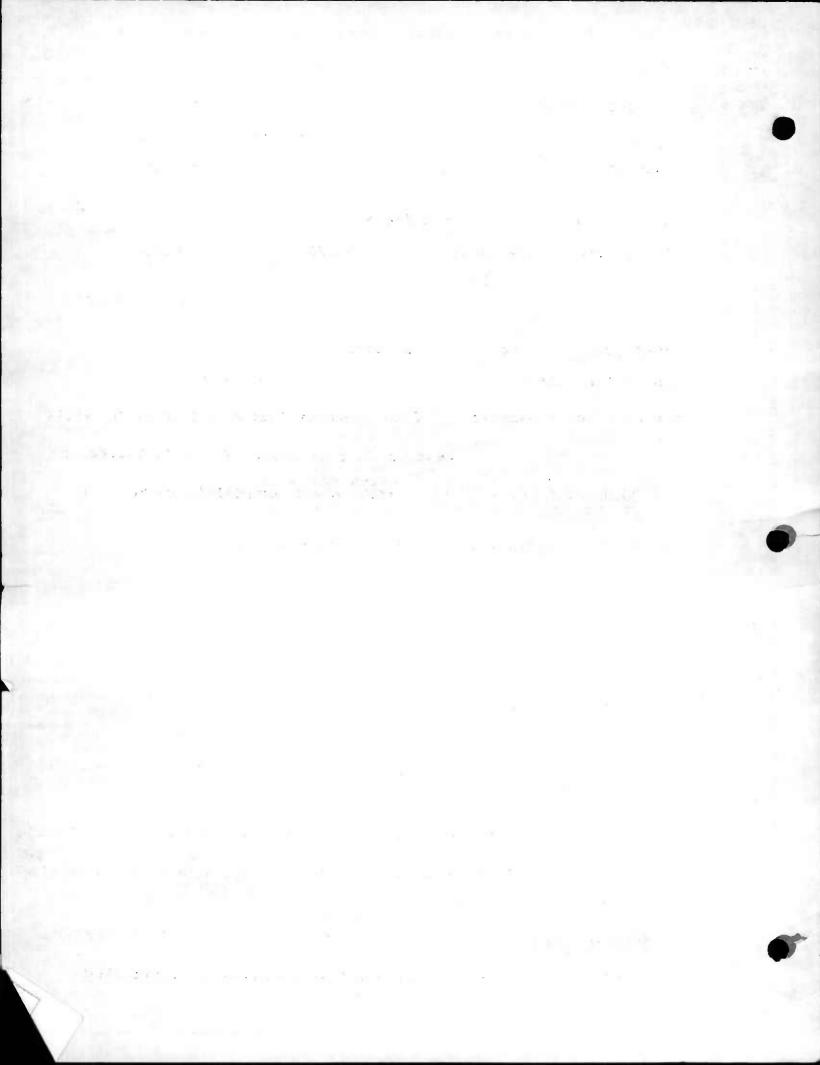
State Registrar



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State of Maryland / Department of Health and Mental Hygiene 98 23403

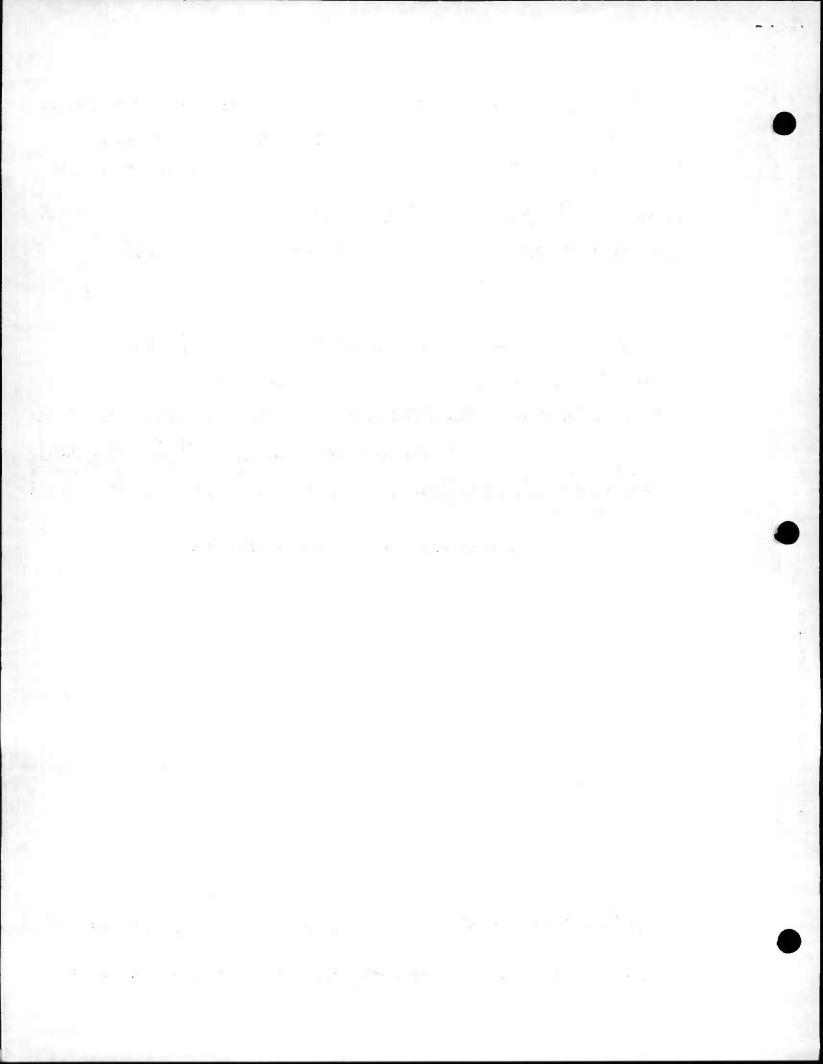
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' /Medical Examiner	An English Stome His not inntitudi		d number)			4	b. City, To	wn, or Lo	cation of Deat	th 4c. (County of	Death	
Examine		CDTTAT					BALT	IMOR	E		NΔ		
Famous	UNIVERSITY HO	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bi	irth		9. Birthpl	ace (State or Foreign
Funeral Director	212-58-5050	12 M 2□		Yrs.	Months	Days	Hours	Min.	(Month, D	_	Ac. County of Death NA Year) 4c. County of Death NA Year) 49 9. Birthplace (State or Country) MD 10d. Inside City 149 Yes 2 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Action of Town, State, Zip Code) timore Md 21229 20c. Location - City or Town, State Baltimore, Md 10cre Md 21215 Approximate Interval Betwonset and Death of Case and Deat	ry)	
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Her d	Never Married 2 Ma	Arme	d Forces?	1	f Yes, speci	ify Cuba	an, Mexicar	, Puerto	ecify Yes or N Rican, etc.)		Black,	White,	etc.
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2 sho	19e. Informant's Name/Relation	nship (Type, Print)	,	1/ 1/202									
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or othe	20a. Method of Disposition	• 🗆		Placa of Dispo cemetery, crer	sition (Nam netory or of	ne of ther pla	ce)		Date	20c. Lo	cation - C	ity or To	wn, State
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	23a. Part1. Enter the disease, shock, or heart failure. Li.	or complications t st only one cause	on each line.	ith. Do not ent	er the mode	e or ayır	ng, such as	cardiac	or respiratory	arrest,			Interval Between
Physician													Oliset and Death
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Examiner	resulting in death)	a. 2		or as e consec									
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n and rtransit	Sequentially list conditions	В	Due to (or as a consec	quence of):								
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been sign should be										formed?	osy	ava	ailable prior to
has by												of	death?
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tal or Attending P rs after death. al Director: After t led in by the funera	4 ☐ Homicide deter	4 ☐ Homicide determined building, etc. (Specify)							,	,	,		
spital ours a neral D			BACK AL										
Ne Hospital n 24 hours Ne Funeral pletely filled	29a. Certifier 1 Certify (Check only 2 Medical	ing Physician: To	o the best of my kn he basis of examin	owledge, deat ation and/or in	h occurred a vestigation.	at the ti	me, date ar	nd place, ath occur	and due to the	e cause(s) e, date and	and mer	nner as s	tated. the cause(s)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.		and	manner stated.										
To the vithin To the comple	29b. Signature and title of certif	ier			290	. Lican:	se number						Day, Year)
	Machineto.	melled	مو			OCM	E			JUL	Y 28	, 19	98
N	30. Name and eddress of person	n who completed	cause of death (Ite	m 23a) (Type,	Print)								
0	Hongonon		nou was			C+~	oot .	Ral +	imore,	Mary	land	212	.01
State	24 Date filed Weeth Day Ver	01	32. Registre's Sign	shiturg . 4	reilli	DLL.	CCL	TATE C	THOTE	I MAL Y			
Registrar	JUL	2 T 1998	gena De	undoor-D	andalle								1
The Street of			77.4										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 23404

				Certificate	of Death		Reg. No.	
Dhaminia		1. Decedent's Name (First, Middle, L	est)			2. Dete of De Month	eth Dey	3. Time of Death
Physicia /Medic		Kathrun	1. Inanak	1an		July		998 2:20am
Examin		4e. Fecility Name (If not institution, g	ive street end number)		4b. City, Town, o	r Location of Deeth	4c. County	of Deeth
		Stella Ma	Pis		Timan	IIIM	Bal	Limpo
uneral		Social Security Number 6.		lest birthday) If Under 1			h	9. Birthplece (State or Foreig
ector		212-210-2544	1□M 200F	89 Yrs. Months !	Pays Hours Mir	Fish 2	9 1909	Country)
-		Usuel Residence of Decedent				I SOLORO	1101	Maryano
Mal		10e. Stete 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
ust be notified at	ğ	Maryland Balt	IMORO I	Middle K	IVER			1 □ Yes 2 No
- Loc	Funeral Director	10e. Street end Number		10f. Zip C	ode		10g. Citizen of	Whet Country?
	0	804 Aproliff	Dd o	-1	1220		11_	81
9	Jer	11. Marital Status	12. Wes Decedent Ever in t	J,S. 13. Was Deceder	t of Hispenic Origin? (Cuben, Mexican, Pue	Specify Yes or No	14. Rad	ce - American Indian,
	E	1 Never Married 2 Marriad	Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva			rto Rican, etc.)	Ble	ck, White, etc.
	þ	3 Widowed 4 ☐ Divorced	If Yes, Giva Year or Detes:	1 ☐ Yes 2 Ø	No Specify:		Specif	v: White
1	2	15. Decedent's I	Education	16e. Decedent's Usuel (Occupetion		16b. Kind of B	usiness/Industry
DA WANTED	Completed	(Specify only highest g		16e. Decedent's Usuel ((Give kind of work life. DO NOT use	done during most of w retired)	orking	1	,
	E	Elementery/Secondary (0-12)	College (1-4or 5+)	homema	UPP		ham	Q
		17. Fether's Neme (First, Middle, Las	it)	1.01.0110		ama (First, Middle,	Meiden Suman	ne)
	o Be	Monnillo W	BUDILLIA		Vadi	0 Mill		,
	ဍ	19a. informent's Neme/Reletionship	(Time Print)	19b. Meiling Addrass (S	MATC	C CITT	- C/h T	0-4-7-0-4-1
		John G Stagn	ALAM SAM	21160 On Al) Eallo	ALLA BO	A L A A	Stere, Zip Code)
	-	20a. Method of Disposition	what John	Place of Disposition (Neme	Faus N	RIVE DU	MINIOR	A, Ma diocu
		1 Burial 2 □ Cremetion 3		cemetery, cremetory or other	r plece)	July 31	20c. Location	City or Town, Stete
once.		4 □ Donetion 5 □ Other (Spec	ity) St.	Johns Long 1	Speen Como	1998	Hydes	Maryland
once.		21. Signature of Funeral Service Lice	ensea	22. Name and	Address of Facility	vans (mapel	of Chines
ă	1	A PISCA	1 /100	182 2325	VIADU D	1 Time	11/11/11/11	Ald 21003
		23e. Pert1. Enter the disease, or conshock, or heart failure. List only	mplications thet caused the dea	th. Do not enter the mode of	f dving, such es cerdla	ac or respiratory er	rest.	Approximate
an		shock, or heart failure. List onl	y one cause on eech line.		.,			intervel Between Onset and Death
al		Immediete Ceuse (Final						
er		disease or condition resulting in death)	e Arterioso	clerotic Ca	rdiovasc	ular Di	sease	
	5	New York Control of the Control of t	Due to (or es e consequence of):				
	듣		b					
	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events	Due to (or es e consequence of):				
		ceuse. Enter Underlying Ceuse (Diseese or Injury	c					
	n/Medical	thet initiated events resulting in death) Lest	Due to (or es e consequenca of):				
3	Z S							
	an		Q					
	Physicia	Pert II. Other aignificent conditions	contributing to death but not re-	sulting in the underlying ceus	se given in Pert I.	23b. Did 1	obacco uee co	ntribute to the cause of death
	3					10.	ree 2□No	3 ☐ Probably 42 Unknow
	by						20 110	o⊟, %p
	교					24a. Wes	en autopsy	24b. Were autopsy findings
	Completed					perfo	med?	evellable prior to completion of ceuse
	티							of deeth?
						101	es 22 No	1 ☐ Yes 2 ☐ No
	e e	25. Wes cese referred to medical examiner?	112-1			eth (Check only o	ne)	
5 1	၉	1 ☐ Yes 2 ☒ No		ER/Outpatient 3□ DOA		Home 5 ☐ Resid	ence 6 Oth	er (Specify)
completely miled in by the funeral director,	ä	27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of 28c.	Injury et Work?	28d. Describe h	ow Injury occur	red
ğ :	te	2 Accident invastigation	on	М	1 ☐ Yes 2 ☐ No			
	Ĕ	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of Injury - At h building, etc. (Special	ome, ferm, street, factory, o	ffice	28f. Location (S City or Tow	treat end Numb	per or Rurel Route Number,
	Certification:		bullding, etc. (Special	(9)		City of Tow	n, siele)	
	a	29a. Certifier 1 CCertifying P	hysicien: To the best of my kno	owledge, death occurred et t	he time, dete end plea	e, end due to the	euse(s) end me	enner es steted.
:	edical	(Check only 2 Medicai Exa	miner: On the basis of examina end menner stated.	ation end/or Investigation, in	my opinion, deeth occ	curred et the time,	dete end place,	end due to the ceuse(s)
	X	29b. Signeture and little of certifier		29c. L	cense number		29d. Date signe	d (Month, Dey, Yeer)
'		/ Valeno	da My		D 15504		7.2	9 98
	-							
,		30. Nema and eddrass of person who	completed ceuse of death (Iter	m 23e) (Type, Print)				
		Eddie Nakhud	la, M.D. 2301	O Dulaney V	alley Rd	Timon	ium, M	1d 21093
Stat	е	31. Date filed (Month Dep Yar) 0	32 Transmittelly	ture				
		NUL U - W	//\					

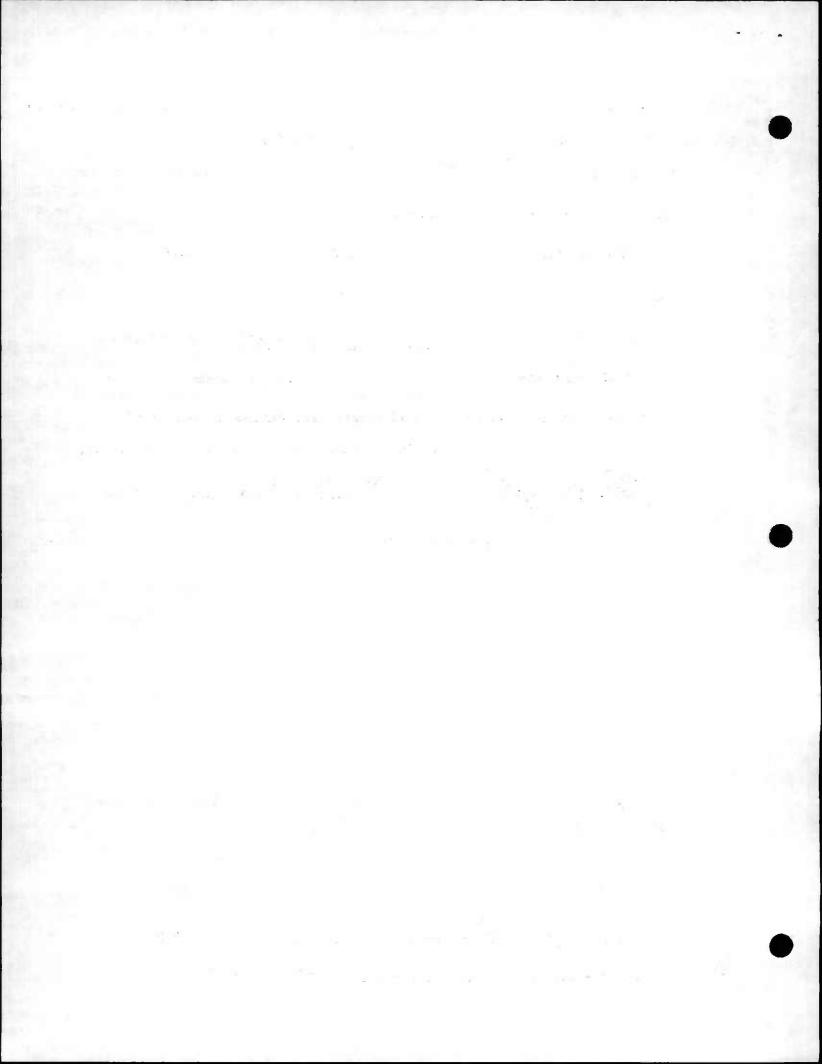
NAME: Shanahan, Kathryn



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dev Month Yeer **Physician** Sto11 98 24-2:00 P.M. /Medical 4e Fecility Neme (If not institution, giva street end number) 4b, City, Town, or Location of Deeth 4c. County of Deeth Examiner 5712 Utrecht Rd. Baltimore Baltimore If Under 1 Year Birthplece (State or Foreign Country) If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2AF Months 87 Yrs Director 1-20-1911 Ireland 118-18-6152 Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City. Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other traumatic event, its Mexical Examinat must be notified at 1 ☐ Yes 2 X No Director Md. Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 21206 U.S.A 5712 Utrecht Rd 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 11. Maritel Stetus 1 ☐ Never Merried 2 ☐ Merried laltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher's Education Aide Education N.Y.C. Board of 17. Fethar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Joseph Mc Carthy Bridget Keene 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5712 Utrecht Rd. Baltimore, Md. 21206 Bridie Irving (Daughter) 20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 🕅 Removel from State St. Michael Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 7-28-98 Astoria, N.Y. 21. Signature of Funeral Service Lic 22. Nama and Addrass of Facility John C. Miller, Inc. 23a. Pent Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or near failura. List only on causa on each line. Approximete Intervel Between Onset end Deeth **Physician** 201245 Immediate Cause (Final disease or condition resulting In death) PNEUMONIA /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. been signed by should be detect 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings evailebla prior to completion of cause of deeth? Completed 24a. Was an autopsy page 2 1 ☐ Yes 2 No 1 TYPS 2 TNO certificete Hospital or Attending Physician: funeral director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Neturel 5 Pending efter deeth. Director: Aft 1 Yes 2 No investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homleide filled in 24 hours e Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Dey, Year) William, in. D 7-25-98 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baltimore, Md. 21218 Dr. Mc Rae Williams 3333 N. Calvert St Agistrer's Signature L 3 1 1998 State Registrar

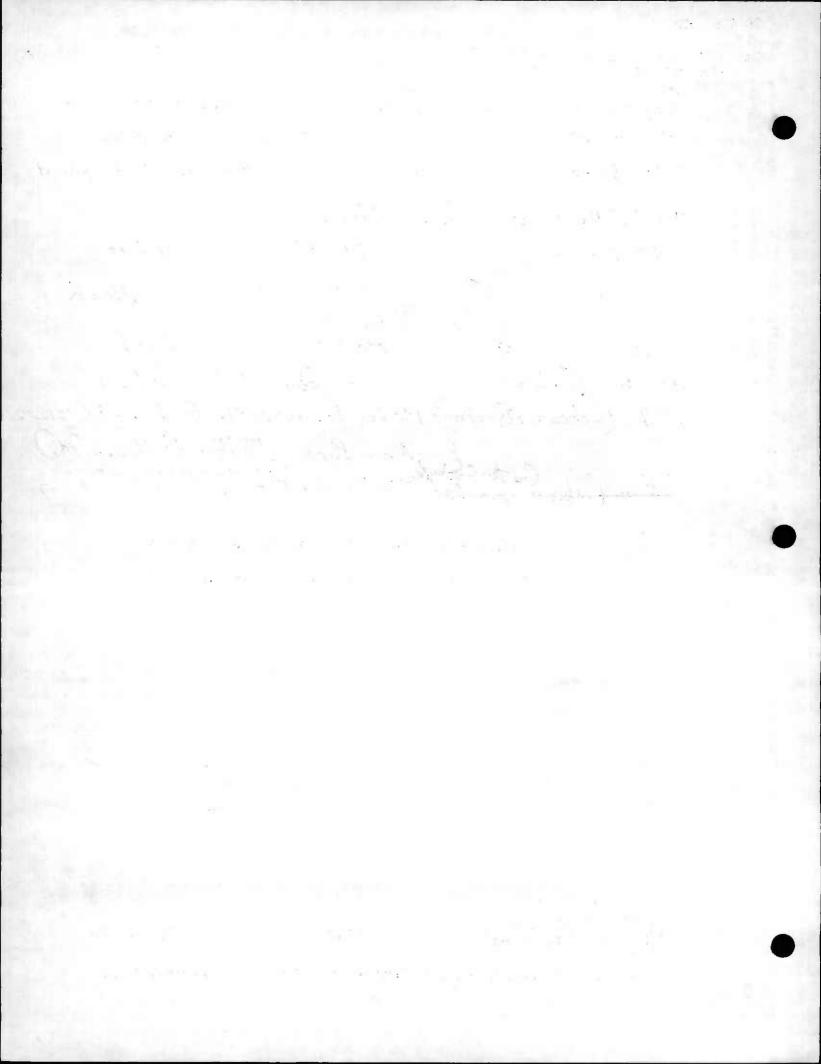


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State of Maryland / Department of Health and Mental Hygiene

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	Ite		21. perFH G761 7/31/98	EW	Certifica	te of	Death	R	g. No.	·	0400
Ш			1. Decedent's Name (First, Middle, Las					2. Date of Deat		Year	3. Time of Death
	Physicia /Medica		tatricia i	liane	lims				27, 199	200	614p
	Examine	_	4a Facility Name (If not Institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
			625 MAIN STREET				DUNDALK		BALTI		
	Funeral Director		5. Social Security Number 6. Se 113-44-8203 Usual Residence of Decedent	7. Age (In yrs.	last birthday) If Und Months	er 1 Year a Days	If Under 24 Hrs Hours Min				ace (State or Foreign ry)
	show	- h	10a. State 10b. County	10c. Cit	ty, Town or Location					10	d. Inside City Limits
	th with the Maryland 23a or 28a-f show ust be notified at	Ö	Maryland Baltis	more Tu	rners Sto	til	m				1 Yes 2 No
	or 28	Director	10e. Street and Number			ip Code		1	0g. Citizen of V	What Count	ry?
	th wit		625 main			212	12		45	A	
	ome 23	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I,S. 13. Was Dec	edeni of h	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America k, White, e	
1020	urs a	p	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		2 No			Specify	Bla	ek
ה	72 h netu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Decedent's Us (Give kind of v	vork done	during most of wo	orking	16b. Kind of Bu	usiness/ind	ustry
7	/ithin	du.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	1	•		11.1-	1	
7			17. Father's Name (First, Middle, Last)	0	MO	5-125		me (First, Middle, I	HOTE	101	
au		Be	n/ 1 - 1	/				FII	77-1	,	
2	thould id Mer marke matic	0	19a. Informani's Name/Relationship (7	DEG 27	19b. Mailing Addre	ss (Street	and Number or F	lural Route Number	City or Town.	Stete. Zip	Code)
M	Ith ar 27 is 1 trau		Will Curher	Rother	-125 Lee	/	wrence	011. 1.	2.11.20	200	45) 51757
ē,	f Has f Has frem othe		20a. Method of Disposition		Place of Disposition (A	ame of		Date	20c. Location -	City or To	wn, State
Ē	Pages anto nt: If i		1 Buriel 2 Cremation 3 4 Donation 5 Other (Specify	Hemovel from State	- Mea-	P	-6	1945	13014	ann	m().
alt	mit. Pa	1	21. Signature of Funeral Service Licens	100	22. Name	and Addre	ess of Facility	dans	ener	1 le	ine
מ	a d a s		MV-11: Cochan	Case By John	W 106/20 1	Te ful	loh stee	Ballis	we f	Vi	2120
	188	+	23a. Part1. Enter the disease, or comp shock, or heart fallure. List only of	lications that caused the deat	th. Do not enter the m	ode of dyi	ng, such as cardia	ic or respiratory arm	est,		Approximate
e.	Physician	1	shock, or heart failure. List only o	one cause on each line.						- 1	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition	a ATHORE	snonic a	as our	DIONEC	upor ous	138°		
	Examiner		resulting in death)		or as a consequence o		700, 200	,,,,			
7	D to	2		, complies	TING DI	Ane	M COPE	Ewitul			
	be axecuted ician and burial-transit	Examine	Sequentially list conditions,	Due to (d	or as a consequence o	f):					
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20		edical	resulting in death) Last	Due to (c	or as a consequence of):				- !	
×	attending	2		d							
00	death e atter	Physician	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	Cause di	ven in Part I	23h Did to	hacco use co	ntribute to	the cause of death?
j.	t the by the tache	l ys	Tartin out of significant containing of	Thousand to down but not not	on the directly the	, outdoo g	voir ii i v dir i.				babty 4 Unknown
S,	gned by										
cords	v requires that the death cer been signed by the attendin should be datached for use	Completed by						24a. Was a perfor		ava	ore autopsy findings ailable prior to impletion of cause deeth?
D L	The law ete has b page 2 s	E						MY	es 2 No		Yes 2 No
VITAL	Physician: The law this certificate has ral director, page 2		25. Was case referred to medical				Of Place of Do	eath (Check only or		1	1 162 5 140
	Physician: this certific ral director,	o Re	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	BER/Outpatient 3□ I	OOA Oti	hor	Home 5 Resid		er /Specify	()
0	a Physer this seral ceral	=	27. Mapner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju Wo		28d. Describe h			,
0	Attending I ar death. ector: After by the funer	atlo	1 Naturel 5 Pending 2 Accident investigation	(Worth, Day Year)	Injury M		Yes 2 □ No				
DIVISION	or Attending I effer death. Director: After I in by the funer	Certification:	3 Sulcide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Specia	ome, farm, street, factor	ory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
5	tal or A	5									
	To the Hospital or within 24 hours effer to the Funeral Dir completaly filled in	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the besis of exemine and manner stated.	owledge, death occurre etion and/or investigation	d at the ti on, in my o	me, date and pled opinion, death occ	e, and due to the curred at the time, d	euse(s) and me ate and placa,	enner es st and due to	eted. the cause(s)
	Within To the comp	Σ	29b. Signature and title of cartifier	. 14			se number	2	9d. Date signe	d (Month, i	Day, Year)
\			Moulinto Un	Mull	φ.	C.M.	E.		July 28	, 199	8
		1	30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type, Print)						
			MINNONOD		dl Penn St	treet	, Baltim	ore, Mary	yland 2	1201	
	State		31. Date filed (Month, Day, Year)	32. Registrante Sign	Andell						
	Registra		100	4							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month enry 4 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore City Joseph Ritchie House N/A if Under 1 Year Months Deys 5. Social Security Number if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) M 2□ F Hours 218-76-0510 1925 Maryland July Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland N/A Baltimore City 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? 828 North Eutaw Street 21201 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None Never Worked N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Vitilio Mary Mazzoni 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony L. Vitilio/Brother 32 Elinor Avenue, Baltimore, Maryland 21236 20b. Placa of Disposition (Name of cemetery, crematory or other place) 7/28/98 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from State Holy Redeemer Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signeture of Europea Service Licenson 22. Name and Address of Fecility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complication shock, or near feilure. List only any saus that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting In death) Myocardial ischemia 30 minutes Due to (or es e consequenca of): Aspiration pneumonitis 4 months Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last Due to (or es e consequence of): 4 years & Gastric cancer and 2° gastrostomt tube 4 months Due to (or es e consequence of): Chronic obstructive pulmonary disease years Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4XXUnknown 1 Yes 2 No 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Was en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel Injury 1 Yes 2 No 2 Accident

Physician/Medicai Examiner The law requires that the death certificate became P.O. Box 68760, signed by Division of Vital Records, þ pege 2 should Completed certificate hes Attending Physician: Be P this s efter death.
I Director: After this
of in by the funeral d Certification: 0 Medicai

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

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Funeral

Director

Pages 1 end 2 should be filled within 72 hours efter death with the Marylend nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "naturel", or Item 23e or 28a-f show

el Hygiene.

permit. Pages 1 end 2: Department of Health er Important: If item 27 is eny Injury or other trauonce.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

7 is marked other than "naturel", or itema 23e or 28a-f show traumetic event, the Medical Examiner must be notified at

To the Hospital o within 24 hours of To the Funeral Di completely filled in

Thomas Powell 31. Dete filed (Month, Day, Year) State JUL 3 1 1998 Registrar

3 Suicide

29a, Certifier

4 Homicide

29b. Signature end title of certifier

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 101 W. Read St.

6 Could not be determined

Baltimore, Md.

💹 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated.

D 13006

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, State)

23 July 1998

29d. Date signed (Month, Day, Year)

32. Registrar's Signeture whit Navidson Randoll

M.D.

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** July 6:30am George Henry Wainwright /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 607 Hillview Road Baltimore N/A 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdav) 8. Date of Birth
(Month, Day, Year)

June 15,1915 Birthplace (Stete or Foreign Country)

Md **Funeral** Months Devs Hours 1 **X**M 2 □ F 214-10-8809 83 Director Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location ral', or Itams 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Md N/A Director Baltimore 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? 607 Hillview Road 21225 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours efter c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Event 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Àq Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12th College (1-4or 5+) Butcher Meat Packing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be George E. Wainwright Viola Jones P 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Olga Wainwright 607 Hillview Road Baltimore, Md. 21225 (Wife(20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removal from State Mt. Zion Cem 07/31/98 Lansdowne, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Caple Funeral Service 5502 Winner Avenue Baltimore, Md 21215 ee or complications thef caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, sist only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Cardiae arren Examiner Physician/Medical Examiner Saquentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Box 68769 resulting in deeth) Last P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Cardierascular descarso voe 2/No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy The law 1 Tes 1 ☐ Yes 2 ☐ No of Vital To the Hospital of Autonomoge within 24 hours effer death.

To the Funeral Director: After this certifical to the Funeral Director. 25. Wes case referred to medical 26. Place of Deeth (Check ogly one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homiclde Medical 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the causa(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) MI 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 32. Registrar's Signeture State tulia Davidson-Handall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23409 Amend: #12 Per FH Film G763 9-3-98RC Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country). **Funeral** Days Hours Months 1 M 2□ F 8-18 Yrs Director Usual Rasidenca of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Islands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal important if then 27 is merised other than any injury or other trauments of the filed within the any injury or other trauments. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 XYas - 2 11 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married Specify: White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retirad) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) owner of business Elementary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Nama (First, Middle, Last, Mother's Nama (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvica Licensee 22. Nama and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final WOON DIV diseasa or condition rasulting in death) Examiner Dua to (o Physician/Medical Examiner Disease MINION YCAVI Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that Initiated evants rasulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760 The law requires that the death certificate be attending physician Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yss 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 ☐ Yas 2 ☐ No 1 Yas

certificate Division of Vital Hospital or Attending Physician: director, this the funeral After death. after death filled in by

25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accidant 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 103 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

103 Certifying Physician: To the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar

29c. License number

within 24 hours a To the Funeral C completely filled

State Registrar

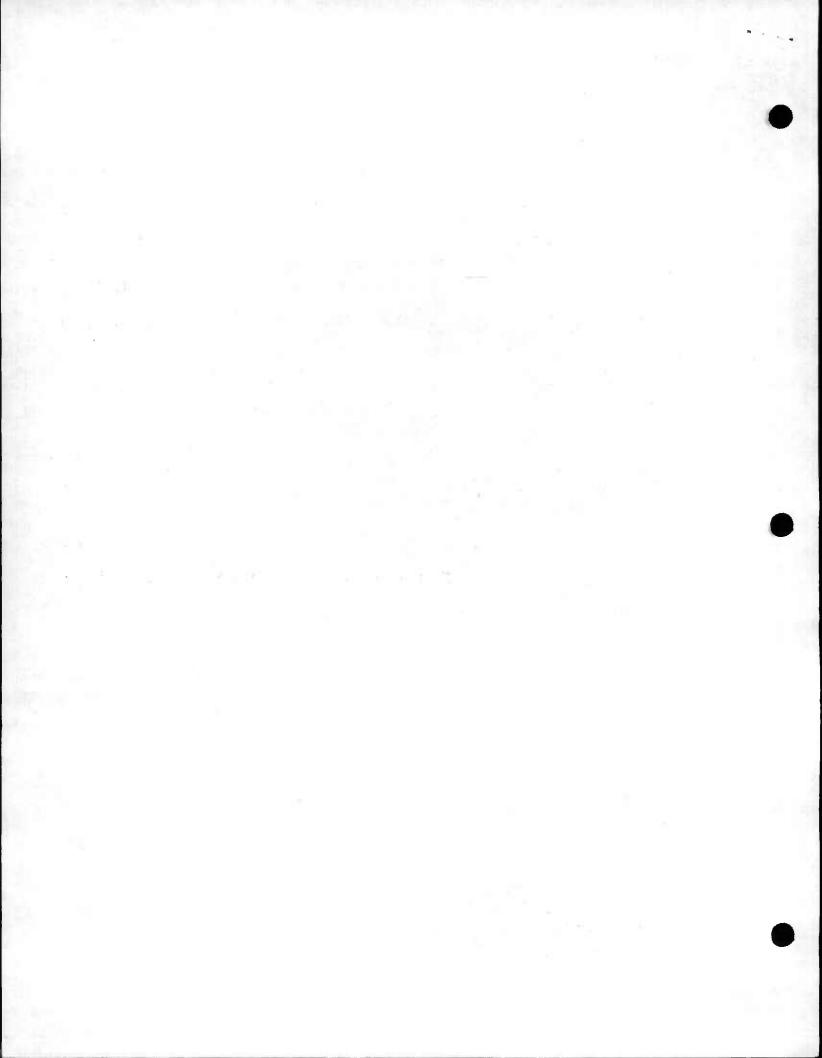
29b. Signature and title of Certifie

29d. Data signed (Month, Day, Yawr)

Hendink sa of death (Item 23a) (Type, Print) 30. Nama and addrass o 31. Data filed (Month Day. 32 Aguistrans Signatura

To the

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23410 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth oosevel NATSON 0932 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford If Under 1 Year if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 1 M 2□ F Months Deys Hours 65 212-82-4720 UNK. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Belcamp 1 ☐ Yes 2X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4346 Foxglove Court 21017 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 1 Yes YNO If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Disabled Never Worked 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) UNK. 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JoAnn Vaughn/caregiver 4346 Foxglove Ct. Belcamp, MD 21017

20c. Location - City or Town, Stete

Queno, Davido sicio no 2107

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be multilast at permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 ia marked other than "natural, or ite any injury or other traumatic event, the Medical Examina. Baltimore, Maryland 21215-0020 **Physician** /Medical

Examiner

is certificate has been signed by the a director, page 2 should be deteched?

After this

To the Hospital or Attanding Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral

Records, P.O. Box 68760

Division of Vital

Physician

/Medical

Examiner

MD

UNK.

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20e. Method of Disposition

1 Burial 2 Coremetion 3 Removal from State 4 Donetion 5 Other (Specify)

Director

Funeral

Completed

Be

Funeral

Director

the Meryland

Metro Crematory, Inc. 7/30/98 Baltimore, MD 2. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signeturar of Funeral Service Licenses 299 Frederick Rd. Balti
23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical thet initiated events resulting in death) Lest Due to (or es e consequênça of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner steted. edical 29a. Certifier 29b. Signature end title of certif 29c. License number 29d. Date signed (Month, Dey, Year) MD 20215

20b. Pleca of Disposition (Neme of cametery, cremetory or other plece)

State Registrar 31. Date filed (Month, Day, Yeer)

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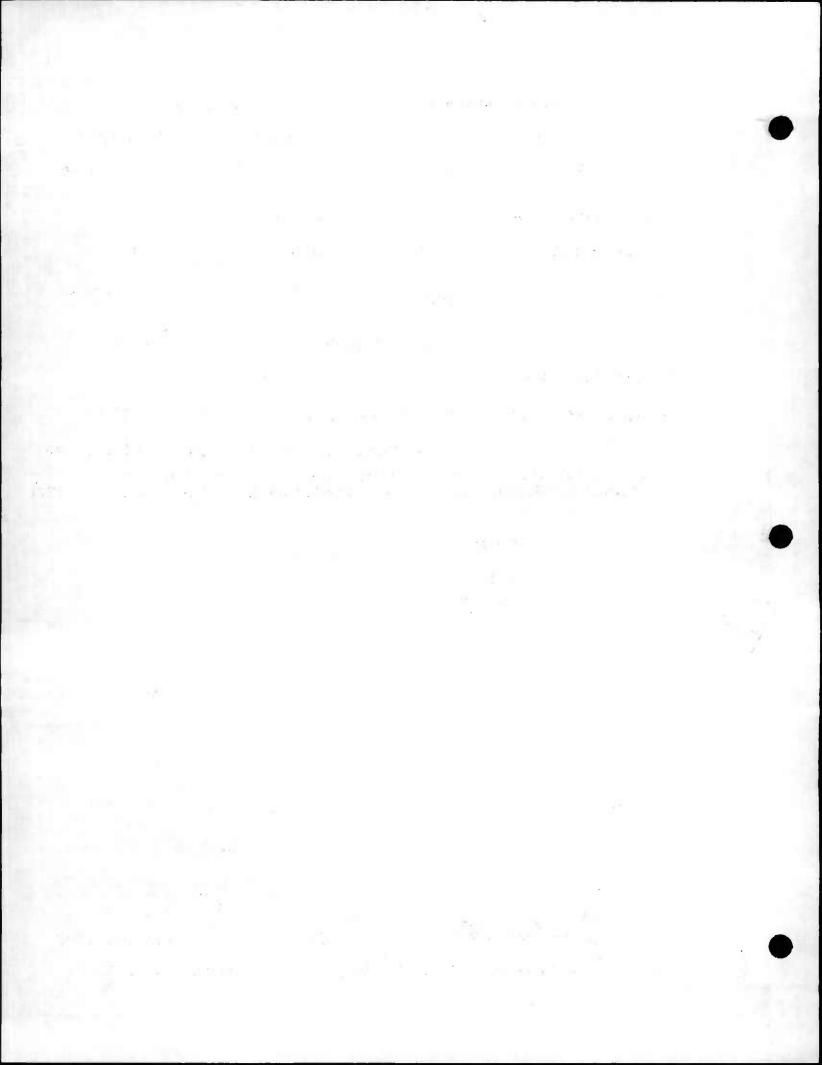
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5 601. Union 32. Registrer's Signature the Davidson

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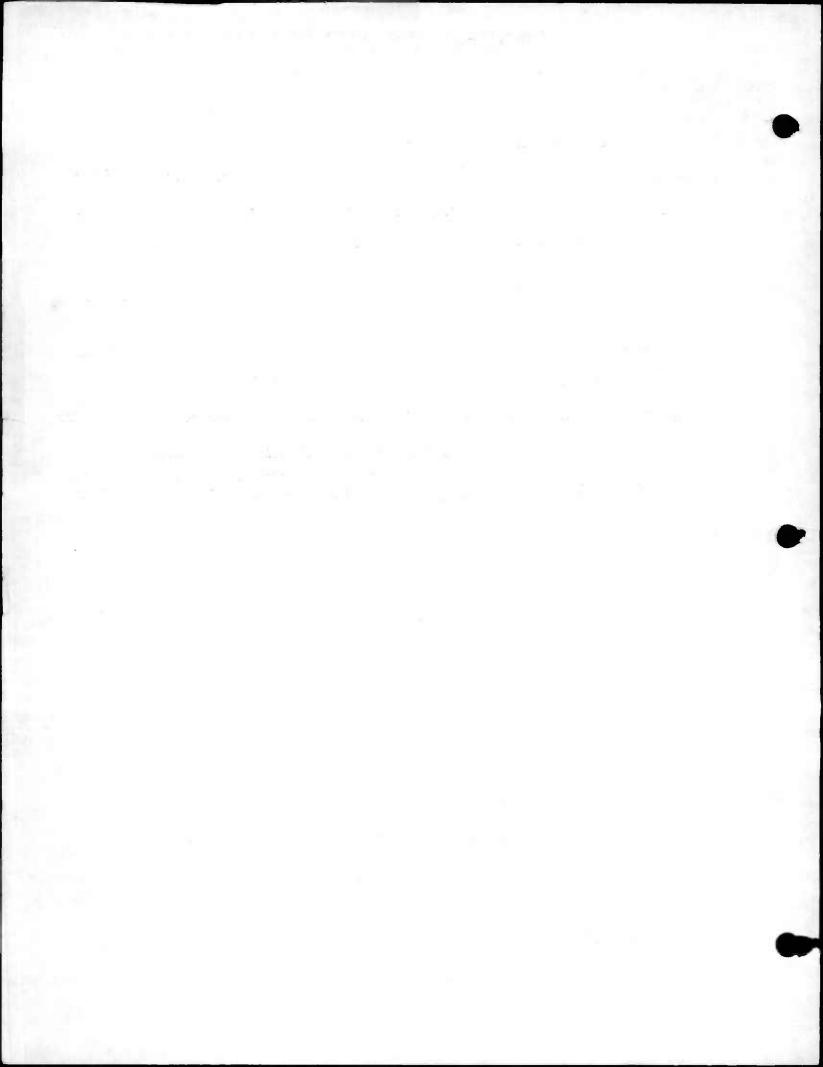
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** Louis V. Williams 98 28 7:35 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner To Medical Center | Davis | 8. Date of Birth | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) | Month, Day, Year) | Aug 5, 1921 Baltimare Veteras Administration Medical Center 6. Sex 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** BALTO 214-18-016 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or frame 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director My d 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours aftar death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mudical Examiner must be in once. ULASKI 212 2227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ZYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DAVIDSON-TRANS Houseman 1291. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be violA. Field 600 2 WIMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PUI 70 2227 PAULINE WILLIAMS 45KI N 20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State GANTISON 7onest 3 4 ☐ Donetion 5 ☐ Other (Specify) OWINGS 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 1727 N. MONTUR Approximate "Intervel Between Onset and Death 11/1 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final 24 hrs Blast Crisis disease or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner Leukemia Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician and Division of Vital Records, P.O. Box 68760 Due to (or as a consequenca of): The law requires that the death certificant 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings eveileble prior to completion of ceuse of death? should ! 24a. Was an autopsy performed? Completed cartificete hes b 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: director 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No this After this funeral 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menper of Deeth 28c. Injury et Work? Certification: 28b. Time of 5 Pending Investigation 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire letaly filled in b Hospital edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completaly 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) To the I within 2 To the F 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUL 3 1 1998

Woo

29b. Signature and title of certifier

3654 Grosvenor Dr. Elligott City, MD 21042 32. Registrar's Signature

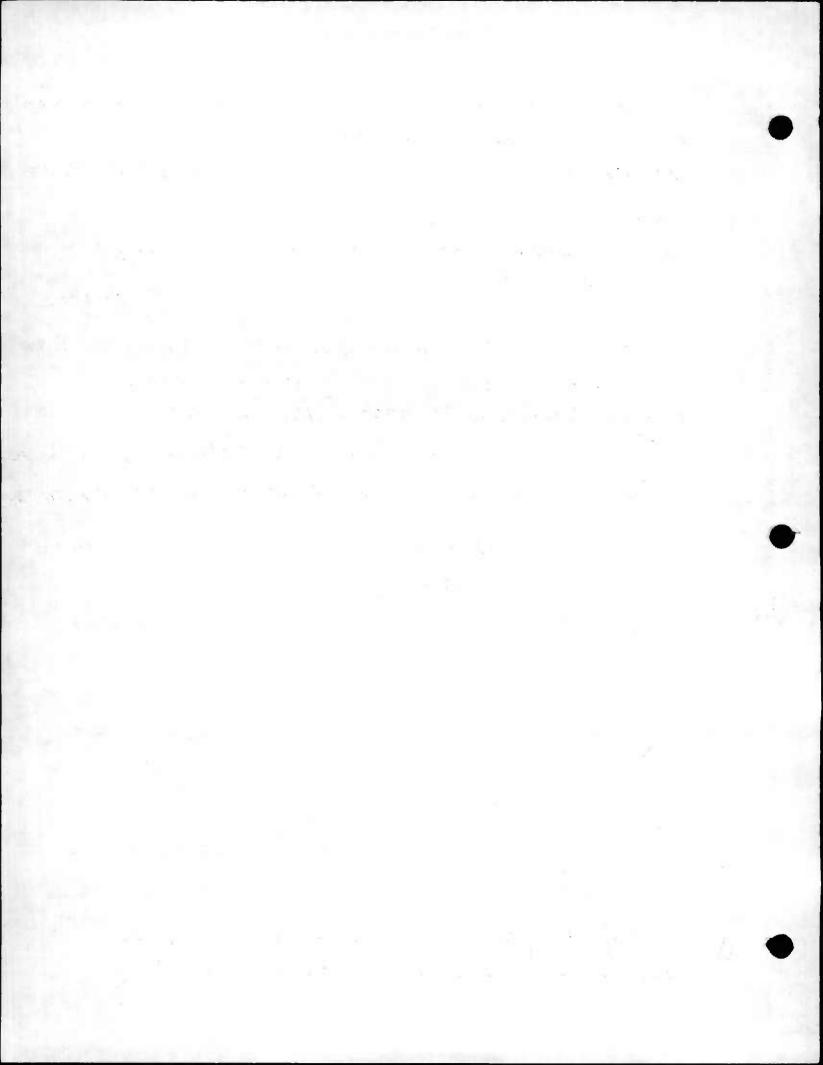
MD

ss of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

AM2556996M111

128/98

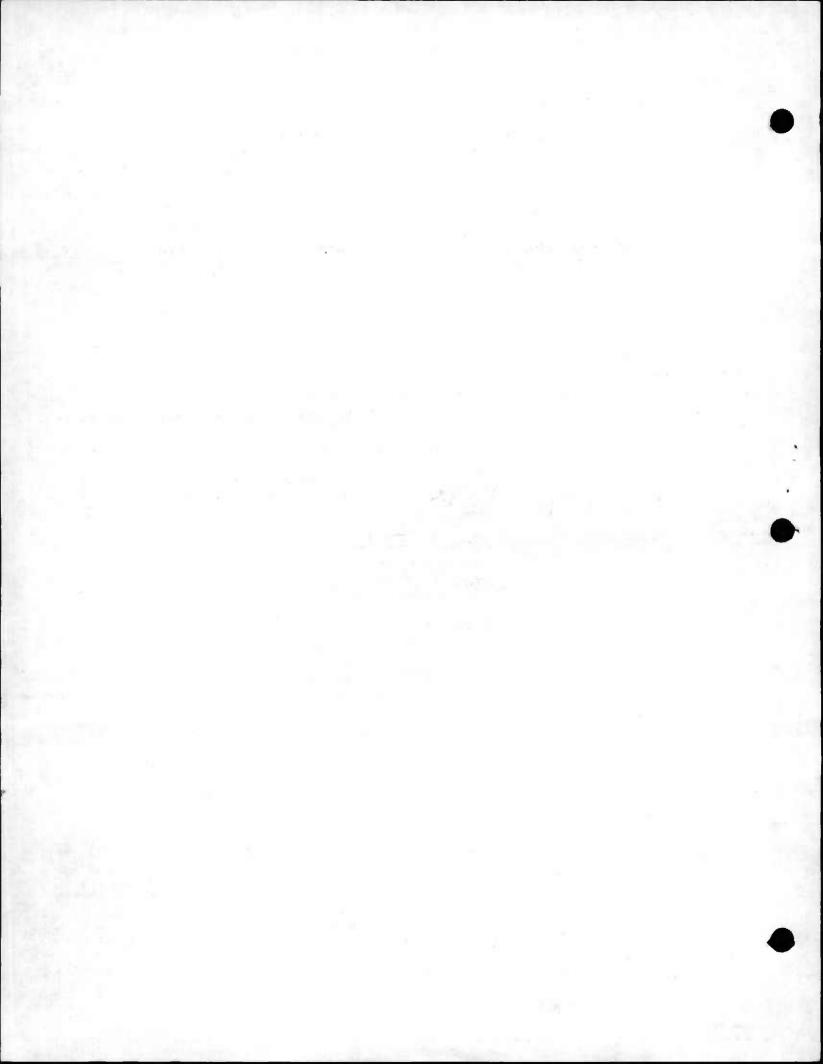


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Irene Eunice Snyder Walder July 1:40 am 30 1998 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner 705 Americana Drive #11 Annapolis Anne Arundel 8. Deta of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M WE Months Deys Hours Yrs. 212-66-6532 88 Director Dec. 25,1909 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. fnslde City Limits Yes 2 No Director MD Anne Arundel Annapolis must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Americana Drive #11 "natural", or items 23a idical Examinar must b 21403 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Merchant Grocery permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if them 27 is marked other any Injury or other traumatic event, QDSs. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) å Max Snyder Mollie Finglass 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Walder - Son 15701 Baden Naylor Road, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removet from State Kneseth Israel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 17/31/98 Annapolis, MD 22. Name end Address of Facility 21. Signature of Funeral Service Aicenses Hardesty Funeral Home, P.A. 23a. Part T. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or raspiratory errest, shock, or heart feiture. List on the cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximete Intervel Batween Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner reart failure Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Dua to (or as a consequence of) Records, P.O. Box 68760 The law requires that the death certificate in Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? this certificate has been signed by the rail director, page 2 should be detached 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Enknown à 24b. Were eutopsy findings evailabla prior to completion of cause of death? Be Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Mospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completely illied in by the funeral director; p 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Deta of fnjury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1833 A. Forest Drive Amapalis, MD tthew J. Malta MO 31. Data filed (Month, Day, Year) 32. Regisfrar's Signature JUL 31 relia Davidson Randall Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer Month 7-E1ma Wickman 25~ 98 3:15 A.M. 4b. City. Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Mercy Hospital - Stella Maris Hospice Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 60 Vr Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1□M 2 F 69 Yrs. 219-30-2351 12-13-1928 North Carolina Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 11 Yes 2 □ No Baltimore Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21231 U.S.A. 1425 Bank St. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1□Yes 2No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Nora Cloud Erby Hawks 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Janet E. Lessner/Daughter Towson, Md. 21286 1107 Green Acre Rd., 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 7-28-98 Baltimore, Md. Holly Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Tonerel Servica Licanso John C. Miller, Inc. Balto., Md. 21206 6415 Belair Rd. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Listonly one cause on each line. Approximete interval Between Onset and Deeth Immediete Cause (Finel diseese or condition resulting in death) PUZMONARY CAMONIC DISTRUCTIVE DISTAGE UNKNOWN Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 25 No 1 Tyes 2 No 26. Plece of Death (Check only one) The Manis Hospies Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT MEXCLY 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28d. Deecribe how Injury occurred

Physician/Medical Examine Records, P.O. Box 68760 been signed by the should be datach Aftar this certificate has funeral director, page 2 Division of Vital or Attending Physician: death. oftar death Director: 2 24 hours eftar Funeral Directors of Filled in b

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/Medical

Examiner

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Pagas 1 and 2 should be filed within 72 hours after death with the Marylen ment of Health and Mentel Hygiene.
ant: If item 27 is marked other than "naturel", or items 23s or 28s-f show ury or other traumatic event, the Medical Exactions must be not lead

permit. Pagas 1 Department of H Important: If its any Injury or ot

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

by g Compie Be 2 Certification:

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Neturel

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

21236

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

29c. License number 040480 29d. Date signed (Month, Dev. Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ferno, ms FERNANDO

Jarron

Bellin Roll 7672 BUIND 040

27, 1998

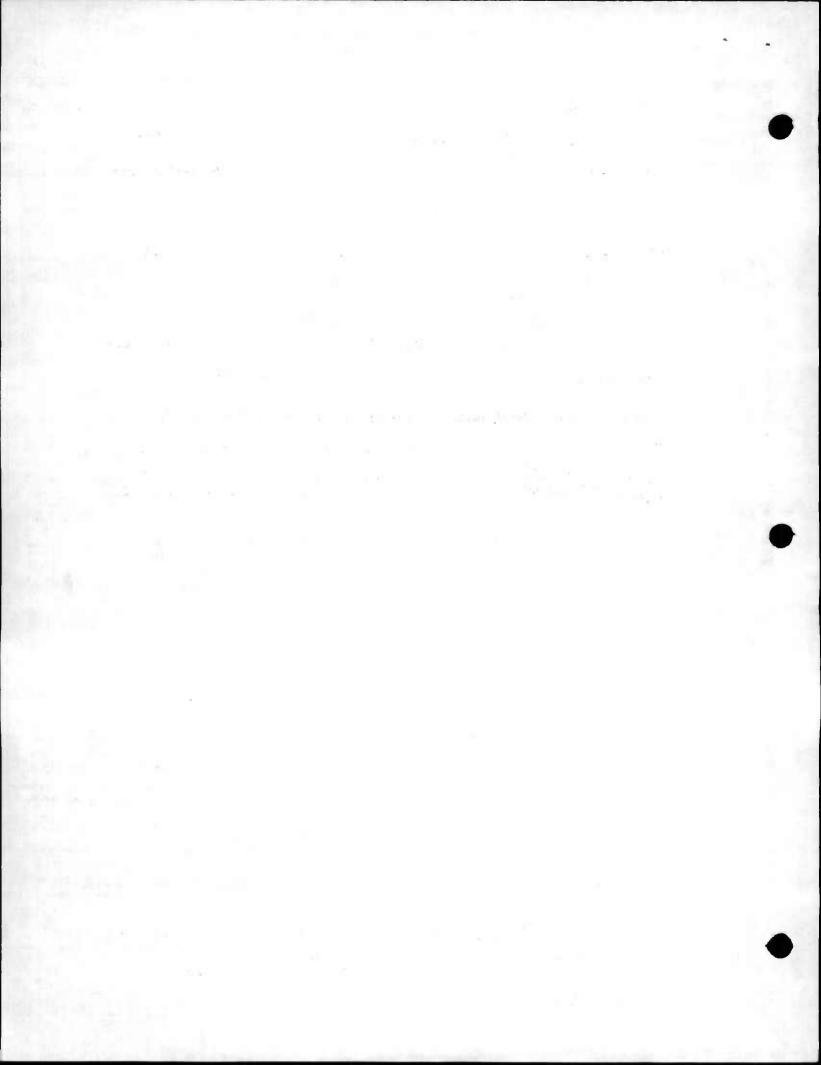
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Hospital

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Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month HELEN BRADY JULY 20, 1998 1220 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth GRAYS CORNER RD., #93 BERLIN WC

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) WORCESTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) 1□ M 20 F Months Days NJ 147-09-2051 Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BERLIN WORCESTER 1 ☐ Yes 25 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11003 GRAYS CORNER RD. #93 21811 USA 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify:WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) ARTHUR MAIERS CHARLOTTE PETERSON 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 11829 GRAYS CORNER RD. RAYMOND R. BRADY 20a. Method of Disposition SON BERLIN, MD., 21811 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 remation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 7-21
22. Name and Address of Facility SALISBURY, MD. 21. Signature of Fune of Service Licen ULLRICH FUNERAL HOME BERLIN 21811 MD. 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death occardial Infanction Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es a consequence of): Due to (or as e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2000 25. Was case referred to medical examiner?

1 Yes 20 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Funeral

Director

if item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumstic evant, the Medical Examiner must be notified at

perma. Pages 1 and 2 should be filed within 7. Department of Heelit and Mental Hygiene. Important: if Item 27 is marked other than "ne any injury or other traumatic event, the Mediconce.

death

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760 The law requires that the death certificate be

Division of Vital

Examiner bunel-tren the attending physician and for use as the buriel the á certificete has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Medical

Physician/Medical 2 Completed Be

Certification: To

State Registrar 47 Manner of Death Netural 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

one)

5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Dey Year) 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 2 No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

| Description of the basis of examiner of examiner of examiner of examiner of examiner of the cause of examiner of the basis of examiner of examiner of examiner of examiner of the cause of examiner of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and tie of certifier MU

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

BIVE Benlin Md 2/8/1 ABBOTT 5 10445 Ocean City

31. Date filed (Month, Day, Year)

32. Registrar's Signature Achia Davidsor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Jule FRANCES M. BUCK 0100 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 La. 8. Date of Birth (Month, Day, Year) **Funerai** 1 M 2 M Director 172-01-1175 09/27/13 Usual Residenca of Decadent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits rall, or items 23a or 28a-f show Experient must be notified at Director 1 XYes 2 No Snow Hill Md. Worcester 10e. Street and Number 10f. Zip Code 10g. Citlzen of Whet Country? 400 W. Federal Street 21863 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indlen, Black, White, etc. Was Decadent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) end 2 should be filed within 72 hours after of ealth end Mental Hygiene.

The pracked other than "natural", or field traumatic event, the Medical Example. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No It Yes, Give X Year or Dates: 21215-0020 1 Yes 2 No Specify: 2 Specify: white 3 Widowed 4 X Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 accounting Tincher Lumber Co. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Frank Michael Fisher Birdie Rarick Fisher 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Depertment of Health er
Important: if Item 27 is
eny Injury or other trau 400 W. Federal St., Snow Hill, Md. 21863

20b. Placa of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, State Anna Chevalier 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal trom State 4 Donetion 5 Other (Specify) Whatcoat Cemetery 7/17Snow Hill, Md. 21. Signeture of Funeral Servica Licensee 22. Neme end Address of Facility P.O. Box 87 Snow Hill, Md. 21863 Dennis Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical men Examiner Due (or as a consequence ot) requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last as the buriel-tran Physician/Medical Due to (or es a consequenca of): ed by the attending deteched for use as Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should be 24b. Were eutopsy tindings evallable prior to Completed 24a. Wes an autopsy completion of cause of death? 1 🗆 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes PENO Certification: To this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Division 5 Pending Investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homiclde To the Hospital within 24 hours of To the Funeral Completely filled ** Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

State Registrar

ton

Chay ton 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Lulia Savidson

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Shone Dr. Salisbury, mal

FRANCES

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Examine Funeral Director	er	te Fecility Neme ((If not institution, give							JULY		998	9:21A.M
Director			CALVERT MEMORIAL HOSPITAL						4b. City, Town, or	Location of Deat	4c. County	of Death	
Director							If I look	21 1 Van		Tourity) 7/24/52 New York 10d. Inside City Limits XIXYes 2□No 10g. Citizen of What Country? USA Specify Yes or No- to Rican, etc.) 14. Race - American Indien, Black, White, etc. Specify: White			
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ural'.	d by	3 Widowed		Year or Dates:	1970							wh	
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2 should and Men is marke aumatic	F		L Cawley lame/Relationship (7)	Type Print)		19b. I	Aalling Addre	ss (Stree				Stete. Zip	Code)
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0 2 0	Physician/Medic	that initiated event resulting in death)		d	Due to (or	es e co	nsequence of):					
the e	ysic	Part II. Other signi	ficant conditions of	ontributing to deeth	but not resu	iting in t	he underlying	cause g	iven In Part I.	23b. Dld	tobacco use co	ntribute to	the cause of de
es that the de igned by the be deteched	by Ph	OBESITY								1	Yes 2 No	3 🗆 Pro	bably 4 Unki
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To the Hospital or Attend within 24 hours effer death To the Funeral Directors, completely filled in by the	Certification:	4 ☐ Homicide	determined	28e. Place of Ir	tc. (Specify	me, fam	n, street, facto	ory, office		City or To	(Street end Num wn, State) N COUNTY,		al Route Number,
Hospi 14 hou Funer tely fill		29a. Certifier (Check only one)			of examinati				time, dete end plece opinion, deeth occu				
within 2 To the comple		29b. Signature and	tiffe of certifier	001			2	9c. Licer	nse number		29d. Date signe	ed (Month,	Dey, Year)
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		30. Neme end edd	ress of person who	1	death (Item	23a) (T		Dor	n Street	Raltin			
State		Jennis 31. Date filed (Mor		ite ND	rade Signat		111	rei	m street,	, partill	NIE, Ma	татап	M 21201

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth JULY 15 1998 ear 2154 CROWDER LOWELL LEE 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Prince Frederick Calvert Calvert Memorial Hospital if Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth Month, Day, Year July 29, 1939 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 TTA Months Days Hours VA 58 Yrs. 233 58 8593 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits North Beach MD Calvert YET Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20714 USA 4040 1st Street 12. Was Decedent Ever in U,S. Armad Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 1963-65 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: white 1 Yes 2 No Specify: 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) pressman printing 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Crowder Blaine Bernice Ring William Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 835, North Beach, MD 20714 19a. Informant's Name/Relationship (Type, Print) Jeffrey C. Crowder/son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremetion 3 Removal from State 7-20-98 MD Veterans Cemetery Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 Part . Enter the disease, or complications that shock, or heert feilure. List only one cause of many the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onset and Death Immediete Cause (Final disease or condition resulting in death) END STAGE RENAL DISEASE Due to (or es a consequenca of): HYPERTENSION Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 2 ER/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 16/98 sund no

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, in Machael France.

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The law requires that the death certificate be executed

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To the Hospital within 24 hours e To the Funeral C

30. Name and address of parson who completed causa of death (Itam 23a) (Type, Print)

Prince Frederick, MD 20678

Dr. Peter Wisniewski, M.D. Prince Fred
Data filed (Month, Day, Year)

32. Registrate Signature

32. Registrate Signature

33. Registrate Signature 31. Data filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

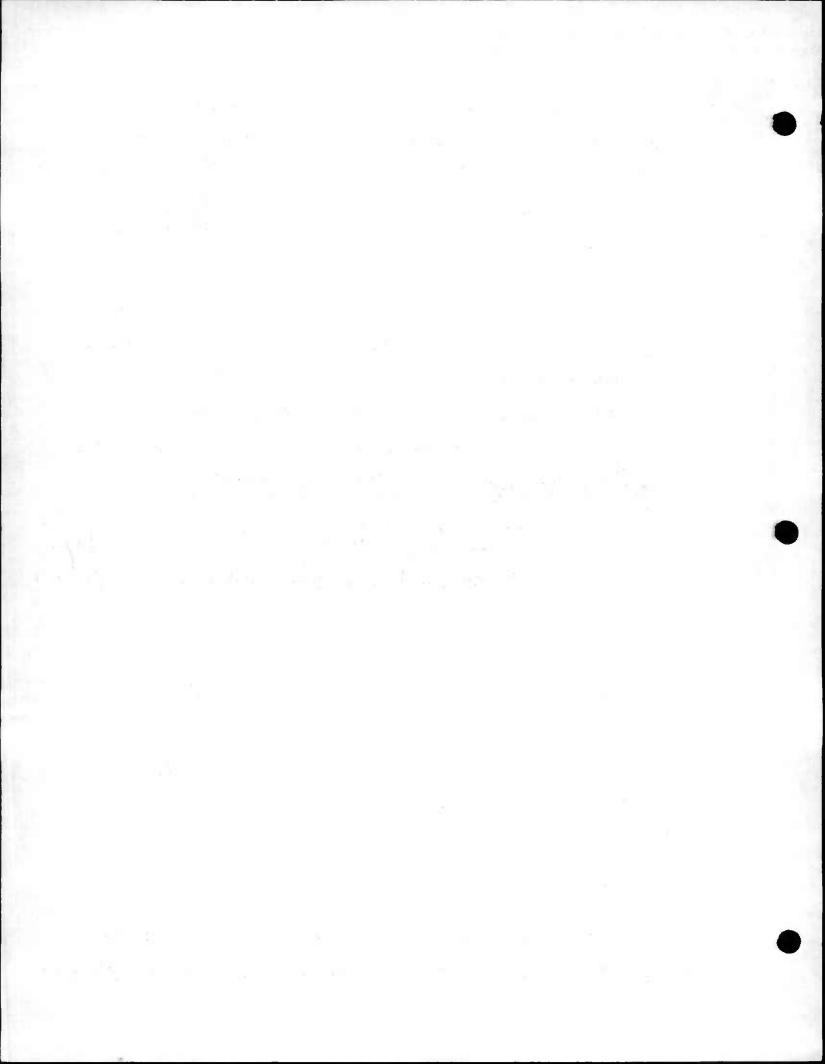
Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death July **Physician** William Solomon Dean 15 1998 4:00 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath **Examiner** 24215 East Cherry Lane Goldsboro Caroline If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Undar 1 Year Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Yrs. 213-18-5026 **Director** Feb 16 1921 Maryland Usual Rasidanca of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits If item 27 is marked other than "natural", or items 23e or 28e-f show or other treumstic event, the Medical Examinar must be notified at 1 ☐ Yas 2 No Director Caroline Goldsboro Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21636 U.S.A. 24215 E. Cherry Lane Funeral Was Dacedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. a filed within 72 hours after d Il Hygiena. other than "natural", or iten 1 ☑Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: 3 Widowad 4 Divorced Black. Completed 15. Decedant's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mantal Hygien Important: If item 27 is marked other the any ijury or other treumatic event, transconce. 11 yrs US Air Force-Dover Base heavy equipment operator 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Calvin Wilson Dean Beatrice Gross Dean 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Numbar, City or Town, State, Zip Code) Nellie L. Dean/ wife 24215 East Cherry Lane Goldsboro, Maryland 21636 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Data 20c. Location - City or Town, Stata ₩ Buriai 2 Cremation 3 Removal from Stata 7/20 4 ☐ Donation 5 ☐ Othar (Specify) Eastern Shore Vet Cem Hurlock, Maryland 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Suse cell lug cancer Immediata Causa (Finai disaasa or condition rasulting in daath) /Medical 13 MW. Examiner Dua to (or as a consequence of) Physician/Medical Examiner bunal-transit Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury and Dua to (or as a consaguance of): attanding physician for use as the buna Records, P.O. Box 68760. certificate be that initiated avants rasuiting in daath) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the detached been signed by the should be detach 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy cartificate hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No. Division of Vital 25. Was casa rafarred to medical axaminar? Be 26. Piaca of Daath (Chack only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 🗷 Rasidance 6 ☐ Othar (Specify) 10 this 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Aftert or Attending 1 Natural 5 Panding invastigation Injury Hospital or Attending n 24 hours efter death.
 Funeral Director: After 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Suicida 28a. Piace of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 2 4 - Homicida Tertifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad.

[2 Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar statad. 29a. Cartifian Medical (Check only To the I 29b. Signatura and 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Easton Ave 2/60/ David Smith, MD Idlewild 31. Data filad (Month, Day, Yaar) 32. Ragistrar's Signatura State 20 - a waitedon Registrar

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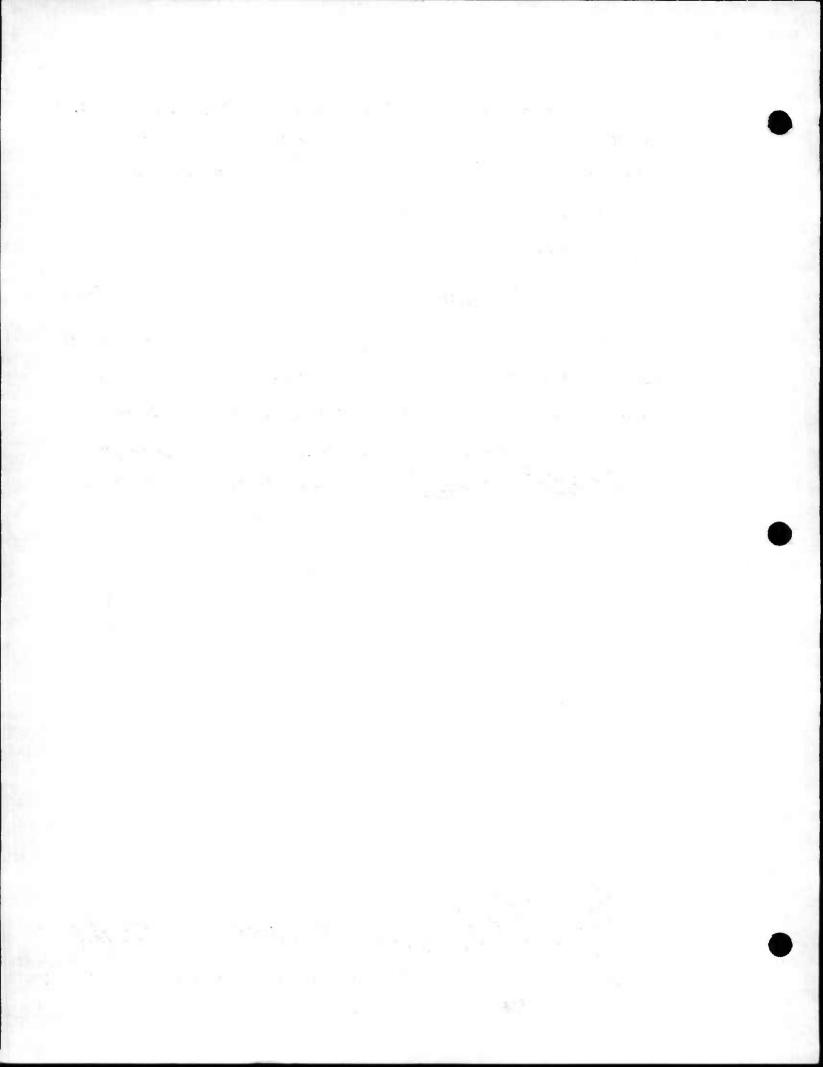
State of Maryland / Department of Health and Mental Hygiene Q Q 21

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Physiciar /Medica		Franklin Ha	mpton Everit	t					July		1998		1140
Examine		4a. Facility Name (If not institution					41	b. City, Town, o	r Location of Dea	th	4c. County	of Death	
		Kent & Oueen	Anne's Co.	Hospi	ital In	ic.		Chest	ertown		Ker	nt	
Funeral		5. Sociel Security Number	6. Sex 7. A	ige (In yrs.	last birthday)	If Under 1	Year Deys	If Under 24 Hr Hours Mir	S. 8. Date of B	irth	arl	9. Birthplac	e (State or Forei
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E mai		19a. Informant's Name/Relations Betty Everitt							Rural Route Num			State, Zip Co	ode)
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= -		1 ☐ Burial 2 ☐ Cremation		0	emetery, crer	natory or othe	er place)				City or Towr	
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important: If it any injury or once.		21. Signature of Funeral Service	Licensee		22	Name and A	Addres	s of Fecility th Fune	eral Hom	e			
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ediçal		Immediate Cause (Final disease or condition	. Kespi	rat	7) ٧	billy	MR					(ave
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director, pag		25. Was case referred to medica examiner?			M		0		eath (Check only	one)			
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To the Funeral Directo completely filled in by the Medical Certific	5			(,								
ly fill	5	29a. Certifier Cartifyir	g Physician: To the best	of my know	wledge, death	occurred at t	he time	e, date and place	e, and due to the	cause	(s) and mai	nner as state	ed.
pletely filed	3	one) 2() Medical	Examiner: On the basis of and manner s	tated.	ion and/or inv	estigation, in	ту ор	inion, death occ	curred at the time	, date	and placa, a	ind due to th	e cause(s)
Z Com		29b. Signature end title of certifie				29c. Li	icense	number		29d.	Date signed	(Month, De	y, Year)
		(D()	50: -		MD	U)	11	499		7	1211	96	
	A	30. Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)	- 0	1 1		t	1211	10	
	1	Day Do	Con 16	A A	1 (Type,	CI	20 5	Ton	01.10	Λ	1	711	217
0.	- 1	31. Date filed (Month, Day, Year)	20 Posisi	rar's Signa	110	,	10-		1000	10		211	20
State Registrar		III) Z		o Janie	ALA TI								



State of Maryland / Department of Health and Mental Hygiene 0 01.00

					Certifica	ate of	Death		Reg. No.	LO O TE LA	
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/Medic			omas Philli	p.	Ellio		Sr.	July 1	17, 1998	7:15 am	
Examin	er	4a. Facility Nama (If not institution, gi	ive street and number)					Location of Death			
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Funeral Director		226 20 7936	Sex 7. Age (fn 72 72	yrs. last birt	rs. If Und Month	ler 1 Yaar s Days		. (Month, Da	y, Year) 5, 1925	9. Birthplace (State or Fora Country) VA	
pue *		Usual Residence of Decedent 10a. State 10b. County	100	. City. Town	or Location				10d. Insid		
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r 28a-f show	rect	10e. Street and Number				Zip Code			10g. Citizan of Wh	net Country?	
death with the Maryland ms 23a or 28a-f show	Funeral Director	4012 6th Stree				2	0714		USA		
	nue	11. Marital Status	12. Was Decedant Evar Armed Forcas?	in U,S.	13. Was Dec	edent of I becify Cub	dispanic Origin? (an, Mexican, Pua	Specify Yas or No- rto Rican, etc.)	- 14. Raca - Black,	- Amarican Indian, White, etc.	
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Men Men arke	ို	Andrew Philip	Elliott				Susie			Carneal	
permit. Pages 1 and 2 should be filed within Department of Health and Martiel Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, the Maconds.		19a. Informant's Name/Relationship Hazel B. Elliott							or, City or Town, Si MD 2071		
othe othe	İ	20a. Method of Disposition		Ob. Place of	Disposition (A	lame of	(ca)	Date	20c. Location - C	ity or Town, State	
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tificate be executed g physician and as the buriel-transit	Medical Examiner	Sequentially list conditions,	Dua	to (or as a c	onsequenca o	f):					
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Physician/Medical Examiner

Be Completed by

Medical Certification: To

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William Lawrence I 19e. Informant's Name/Reletionship (Type, June H. Horner (wi 20e. Method of Disposition 1 Suriel 2 Cramation 3 Ram 4 Donation 5 Other (Specify) 21. Signatural of Luney Sarvice Licenses	5+		Medical	Doc				Hospi		
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4 Donation 5 Other (Specify) 21. Signature of June of Service Licensee		20b. Pleca o	of Disposition ary, cremetory	(Neme of		DC.			- City or Town, St	teta
21. Significant of uneur Service Licensee	novai from Stete		Cemetory		ilace)	17	7-28-98	Stauber) والنبيد)hio
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- h	MEIA	51A111	c 5/1	MALL	CELL	C	ANCER	MFLL	1116	
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest		Due to (or es e	consequence	e of):			1.00	V		
d										
Pert II. Other significant conditions contrib	outing to death b	out not rasulting i	in tha underlyi	ing cause (given In Pert I.		23b. Did to	/	ontribute to the c	cauae of death?
							24a. Wes e perform		eveilable	ion of causa
							1 🗆 Ye	es 2 No	1 □ Yes	
25. Wes case referred to medical axeminer? 1 \sum Yes 2 \sum No Hos	spitel: 1 Inpatio	ient 2 ER/O	outpatient 3[□ DOA C	Other:		th <i>(Check only on</i> ome 5 ☐ Reside		her (Specity)	
27. Manner of Death Villature 5 Pending Accident investigation	28a. Dete of Inju (Month, Da	ury 28b.	Time of Injury	28c. Inj W	njury et Work? 1 🗆 Yes 2 🗆 N		28d. Describe ho			
2 Cuiside 6 Could not be	28e. Pleca of in building, el	jury - At homa, fa tc. (Specify)					28f. Location (Si City or Town		ber or Rural Rout	e Number,
29a. Certifier Certifying Physici (Check only 2 Medical Examiner		of examinetion en								euse(s)

12137 ELM STREET, PRINCESS ANNE, MD 21853

SIATE PHYSICIAN

32. Registrer's Signature

Guiden Randore

completed cause of deeth (Item 23e) (Type, Print)

GARUBA, MD

2 2 1998

JULY 21 1998.

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.

To the Funeral Directors After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

Registrar

State

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The Table 1997

s. Historian Mills

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death July HARRTS WARD 2357 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Calvert Memorial Hospital Prince Frederick Calvert 6. Sex 1 M 2 □ F If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year) Oct. 15,1930 Birthplece (Stete or Foreign Country)
 Maryland 7. Age (In yrs. lest birthdey) Months Hours Yrs Oct. 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Calvert Owings 10f. Zip Code 10g. Citizen of What Country? Briscoes Turn Road 20736 USA 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bieck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merrled 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorcad 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Farmer Farming 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Harris Nettie Giles 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6695 Briscoes Turn Rd. Marlene Reid/Granddaughter Owings, MD 20736 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stele Buriel 2 Cremetion 3 Removel from Stele Solid Rock Church Cem. 7/11/98 Port Republic, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licensee 22. Neme end Address of Fecility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth 6€ Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably

Physician /Medical Examiner

signed by the attending physician and debt detached for use as the buriel-transit

cate hes been sig., page 2 should b

this certificate hes

To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Certification:

certificeta be axecuted

P.O. Box 68760,

Records.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylai Department of Heelth and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0020

with the Maryland

HUGH

5. Social Security Number

220-28-5195

10e. Stete

Maryland

6695

10e. Street and Number

Phillip

20e. Method of Disposition

Immediate Cause (Finel disease or condition resulting in deeth)

Usuel Residence of Decedent

Examiner Physician/Medical p Completed 25. Wes case referred to medical Be 2

Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24a. Wes en eutopsy performed?

2 300 1 Yes

24b. Were eutopsy findings evalleble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

examiner? Hospitei: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpelient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

1 Divature 2 Accident 3 Sulcide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred el the time, date end place, end due to the ceuse(s) end menner steted. 29b. Signature and little occurifier 29g License number 29d. Dete signed (Month, Dey, Year)

30. Name end eddfess of person who completed cause of deeth (Item 23a) (Type, Print) Joseph J. Barth III, M.D.

Prince Frederick, Maryland 20678

State Registrar 31. Dete filed (Month, Day, Year)

. 6

32. Registrer's Signature Julia Davidson Rardall Frank III we are delicated was stated to the property of the first

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Daath 3. Time of Deeth Month JOHN 8 15:52 KENNEDY 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth BERLIN II Under 24 Hrs. Hours Min. ATLANTIC GENERAL HOSPITAL WORCESTER If Under 1 Months 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) Days M 2 F Yrs. 579-28-2192 Usual Residence of Decedent 2-29-22 WASH., DC 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. WORCESTER OCEAN PINES 10 Yas 2 No 10e. Street and Number 10f. Zip Coda 10a. Citizen of What Country? 1268 OCEAN PARKWAY 21811 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 PYas 2 □ No If Yas, Giva Yaar or Datas: WW II 11. Marital Status 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, White, etc. 1 Navar Married Married 1 ☐ Yas ak No Specify: Specify: 3 ☐ Widowad 4 ☐ Divorcad WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacadant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) SPECIAL AGENT FBI 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) WILLIAM KENNEDY CORA SWEENEY 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Numbar, City or Town, State, Zip Coda) 1268 OCEAN PKWY . OCEAN PINES, MD., 21811 20b. Placa of Disposition (Nama of carnatary, crematory or other placa) Date Date Date CHARLOTTE M. KENNEDY 20a. Mathod of Disposition 1 ☐ Burial 2 🕊 Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Spacify) 7-21 SALISBURY CREMATORY SALISBURY, MD. 22. Nama and Address of Facility ULLRICH FUNERAL HOME BERLIN Mp., 21811 Port I. Enter the disease, of demplications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat end Death Immediata Causa (Final disaase or condition rasulting in daath) d24 Dua to (or es a consequança of): Sequantially list conditions, if any, laading to immediata ceuse. Entar Underlying Causa (Diseesa or Injury thet initiated avents rasulting in death) Last Due to (or es a consequence of): Dua to (or es a consaquance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa centribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown pullmonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarrad to madical axaminer? 26. Placa of Deeth (Chack only one) 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatlant 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Yaar) 28d. Dascriba how injury occurred 28b. Tima of 28c. Injury et Work? 5 Panding investigation 1 Watural

buriel-tran and attending physician for use as the burie Records, P.O. Box 68760 or Attanding Physician: The law requires that the death Division of Vital director, this After this To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

Physician/Medical Examiner Completed by Be ٩ Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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tem 27 is marked other than "naturel", or items 23e or 28a-f show other traumatic event, the Modical Examiner must be notified at

filed withi Hygiene.

end 2 should be ealth and Mental

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

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Registrar

Medical

29b. Signetura and title of certifiar

6 Could not be determined

2 Accident

3 Suicida

29a. Cartifier (Check only one)

4 Homicide

510/6.

29c. License number

1 ☐ Yes 2 ☐ No

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted. 29d. Date signad (Month, Day, Yaar)

28f. Location (Straat and Number or Rurel Routa Number, City or Town, Steta)

ated cause of death (Itam 23a) (Type, Print) 30. Nama and address of person who 9732

31. Data filad (Month, Day, Year) 32. Ragistrar's Signature

Swhia Savidon

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

- L.

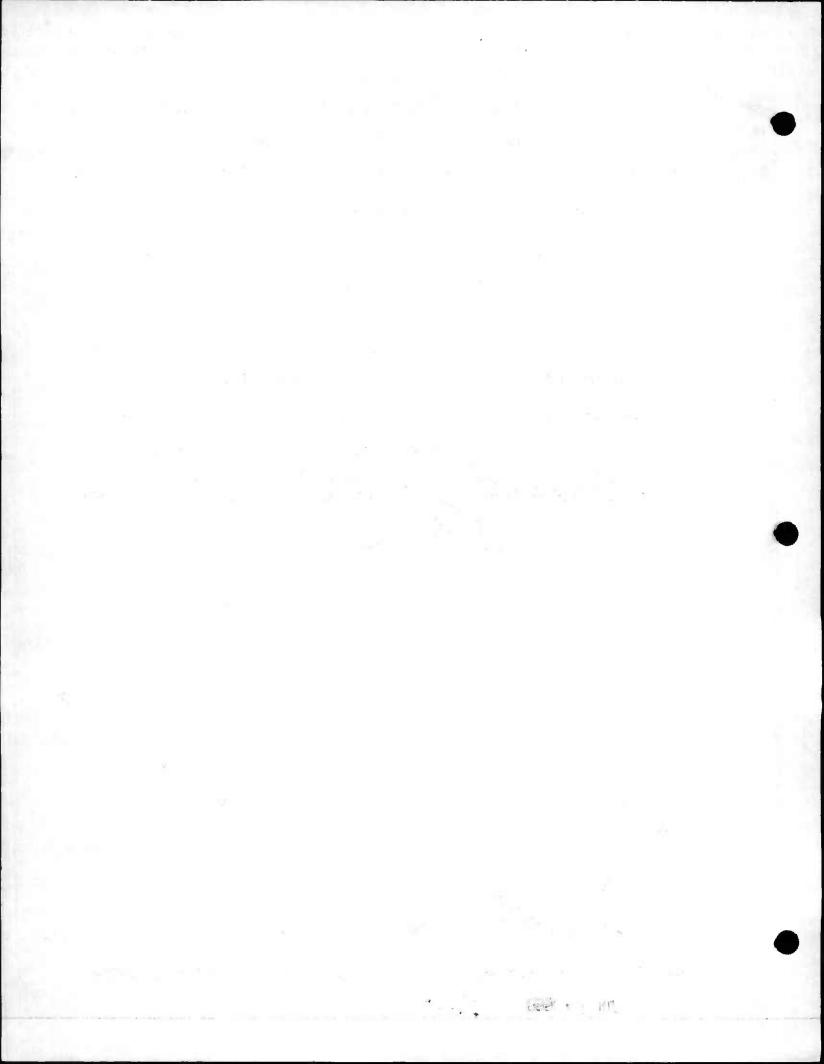
State of Maryland / Department of Health and Mental Hygiene

23428 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dey Month **Physician POULSON** July 11, 1998 9:01 PM LAMBERTSON /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2534 Worcester Highway Pocomoke City Worcester If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
October 8,1919 If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 229-09-7408 Director 78 Virginia Usual Residence of Decedent 10a. Stete 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Marical Examinat must be not filed. 10d. Inside City Limits Maryland Worcester Pocomoke City Director 1 ☐ Yes 2X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2534 Worcester Highway 21851 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: à Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Retail Dry Goods 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be John William Poulson Ethel Simpson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Connie Magann/Daughter 4235 Fletcher Ct., Chesapeake, VA 23321 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Surial 2 ☐ Cremetion 3 ☐ Removel from State Groton's Cemetery 4 Donetion 5 Other (Specify) 7/15/98 Hallwood, VA of Fundral Service License 22. Name end Address of Fecility Holloway-Melson Funeral Home 23a. Party Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approximately an experiment to the disease or complications that caused the death Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approximately an experiment to the disease or complications that caused the death Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Intervel Between Onset end Deeth Physician Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical umo Examiner Due to (or es e consequence of) ettending physician end for use es the burief-transit The law requires that the death certificate be executed Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that he interest cause) Due to (or es e consequence of): Records, P.O. Box 68760. Physician/Medical thet initieted events resulting in deeth) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contribute to the ceuee of deeth? P 1 Yes 2 No 3 Probably 4 Unknown signed b by 24b. Were eutopsy findings eveileble prior to Completed 24a. Wes en eutopsy completion of cause of deeth? 1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and finer stated. 29a, Certifier 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 14, 1998 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) IGNATIUS L. DINARDO, SALISBURY, MD. 21804 M.D. 106 MILFORD ST. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State Tavidson-Randall Registrar JUL



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** FAUVIA MCCLELLAND July 16, 1998 0610 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Calvert County Nursing Center Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Feb 14 1 (ear)
9. Birthplece (State or Foreign Country)
Kentucky 6. Sex **Funeral** Months 1□ M 2XF Yrs. 372 16 7249 Director Usual Residence of Decedent 10a: Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinal must be notified an edge. Maryland Calvert Port Republic 1 ☐ Yes 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2018 Daffodil Rd. 20676 United States Funeral Race - Amarican Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes X□ No Specify: þ 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) school teacher public 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be James Henry Hall Mary Elizabeth Bell 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mark H. McClelland- son same as 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☑ Removal from State Briensburg Cemetery July 20 1998 Calvert City Kentucky 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility Rausch Funeral Home PA 21. Signature of Funeral Service Licenses Mario 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Congestive that Failure attending physician and d for use as the burial-transit certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? as been signed by the 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Nisease, Lyng Cance Records, 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Failure 1 ☐ Yes 200 No 1 Yes 2 No certificate Division of Vital a Hospital or Attanding Physicien: 24 hours after death.
a Funeral Director: After this certifical lefely filled in by the funeral director, p. 25. Wes case referred to medicat B 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely fi 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Jonathan Lowenthal, M.D. Prince Frederick, Md 20678 32. Registraris Signature 1998 Julia Stavelean Randall Registrar

		State of Maryland / Department of Health an Certificate of Death		g. No.	23430
Phys /Me	ician dical	1. Decedent'a Nama (First, Middle, Last) Margaret Swindell Remsburg	2. Date of Death Month July 1	Day 1998	3. Tima of Death
Exan		4e. Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	4c. County of De	eath
		Anne Arundel Medical Center An	napolis	Anne A	rundel
Funera Directo		5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Yrs. 79 Yrs.	viin. (Month, Dey,	Year) 9. E	Birthplaca (State or Foreign Country) NC
p .		Usual Rasidence of Decedent 10e. State 10b. County 10c. City. Town or Location			
enyle show	2				10d. Inside City Limits 1 ☐ Yes 2X☐ No
he M	Director	110 Mile Middel Rose Mayer			
23a or	rai Dir	10e. Street and Number 7055 Boston Ave 20714	10	og. Citizen of What USA	Country?
DEJILITIOTE, METYIBING Z1Z13-UUZU permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than *natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redified at	by Funeral	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Yaar or Detes:	? (Specify Yas or No- uarto Rican, etc.)	14. Race - Al Bieck, W Specify:	merican Indian, hite, etc. white
Maly janua 2 12 13-0020 nd 2 should be filed within 72 hours eft this and Mental Hygiens 77 is marked other than "natural", or reaumetic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	working 1	6b. Kind of Busine	ss/Industry
A Signatura	E O	1 beautician-sel	f empl.	Cosmet	ology
verit,	Be	17. Fathar's Name (First, Middle, Last) 18. Mothar's	Nama (First, Middle, M		
Wid b Ments	To E	William Eli Swindell Ber	tha		Sawyer
Midir y		19e. Informent's Name/Ralationship (Type, Print) William E. Remsburg/son 19b. Mailing Addrass (Streat and Number of 16007 Audubon Ln			
Deficiency of the post of the		20a. Mathod of Disposition 20b. Place of Disposition (Name of	Dete 2	Oc. Location - City	or Town, State
Pege ento		to Burial 2 Cremation 3 Removed from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Fort Lincoln Cem.	7-18-98	Brentw	ood, MD
mit. I		21. Signature of Fungue Service Lieunsee 22. Name and Address of Facility			
E E E	MUCE	Rausch Funera	1 Home O	wines	MD 20736
		The fifthering to have			
Dhynisia		■3a. Part1. Enter the disease, or compilications that occupied the death. Do not enter the mode of dying, such as car shock, or heart failura. List only one cause on each line.	diac or respiratory arre	at,	Approximate Interval Between Onset and Deeth
Physicia: /Medica	_	Immediate Cause (Finel			
Examine	r	Immediate Cause (Finel disease or condition resulting in death) a. Suptre 5 to CR Due to (or as a consequenca of):			
	ě	Due to (or as a consequenca or):			
ficete be executed physician end is the buriel-trensit	Examiner	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Causa, Olisease or Injury b. Do we / in farcto. Due to (or as a consequence of): UGIL he momb	6 7		
an er	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	200		
ficete be ex physician is the burie	edicai	Causa (Diseese or Injury that initiated events resulting in death) Lest Dua to (or es a consequenca of):	ast		1
ntifice ng ph		resulting in deadil) Lest			
eath certifi	Zue	d			
deat death	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.	23b. Did tob	pacco use contribu	uta to the cause of death?
of the et the etache	Physician/M		1 □ Ye	8 2□No 3□	Probably 4 Unknow
gned be de	by				
The law requires that the death certificate lass been signed by the attending page 2 should be detached for use e	Completed		24a. Was an perform	eutopsy ed?	b. Were eutopsy findings available prior to completion of cause of death?
The lav	mo		1 ☐ Ye	s 200 No	1 ☐ Yes 2 ☐ No
	BeC	25. Wes case referred to medical 28. Place of	Deeth (Check only one		
s car direc	ToB	Hospital: 1	ng Home 5 ☐ Rasidar		nacifu)
Phys er this		27. Manner of Death 28a. Date of injury 28b. Tima of 28c. Injury et	28d. Describe ho		овспу)
Attending Physician: or death. ector: After this cartific by the funeral director,	atio	1 Naturel 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No			
I or Attending Phys after death. Director: After this	Certification:	3 Sulcide 6 Could not be determined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,		Rural Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place of the control	laca, and due to the cel occurred at the time, de	use(s) and manner te and place, and d	as stated. lue to the cause(s)
ithin o the	Me	29b. Signatura and title of certifier , 29c. License number	29	d. Date signed (Mo	nth, Day, Year)
F 3 F 8		1 2 6 1 1t ma 1202	43	2/1	1/9/
		20 Name and address of successful associated	7)	7/10	1/8
15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 205 /6	id /.	0	Annagolis
		31. Dete tiled (Month, Dey, Year) 32. Registrate Signature	, a Jely	rive	Managalis

Registrar

State of Maryland / Department of Health and Mental Hygiene

	Div.	M	1. Decedent's Name (First, Middle, La	ist)	7/1	Corum	cate of	Douth	2. Date of Daat		Voer	3. Time of Deeth
	Physic /Medi			. SPENCE	3				July	Day 15,199	Year 8	10 :00 an
	Exami		4a. Fecility Name (if not institution, give					4b. City, Town, or		4c. County o		
	Funeral				e (In yrs. last b	Mo	Under 1 Year		8. Date of Birth			ster ace (State or Foreign
	Director		219-05-3845 Usual Residence of Decedent	ILIM ZLAF	95	Yrs.			7-08-0	3	Onl	éy, Va.
	yland		10a. State 10b. County		10c. City, To	wn or Location	n				10	Od. Inside City Limits
	e Mar	Director	Md. Wo	rcester	Sno	w Hil	1					1 → Yas 2 □ No
	with th		10e. Street end Number			10	of. Zip Code		1	0g. Citizen of W		ry?
	Jeath ins 23	Funeral	205 E. Market	12. Was Decedant	Evar in U.S.	13. Was I	218 Decedent of		Specify Yes or No-	U.S.	A .	an Indian.
21215-0020	4 within 72 hours efter death with the Maryland Jiene. Then "natural", or flems 23a or 28a-f show The Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 3 ☑ Wildowed 4 □ Divorced	Armed Forces? 1 Yes, Give Year or Dates:			specify Cut	Hispanic Origin? (S pan, Mexican, Puer Specify:	to Rican, etc.)		, White, e	etc.
5-0	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gre	ducation ade completed)	160	Decedent's	Usuel Occu	petion during most of wo	rking	16b. Kind of Bus	siness/ind	ustry
121	within ene. than "	jumo	Elementary/Secondary (0-12)	College (1-4or 5	i+)		or use retire maker			own h	0.000	
d 2	Hygi other	Be Co	17. Father's Neme (First, Middle, Last)		HOME	maker		me (First, Middla, M			
ylar	ges 1 and 2 should be filed to f Haalth end Mental Hyg If Item 27 is marked other or other traumatic event,	To B	George Tom Guy					There	essa May	Guy J	enk	ins
Maryland	2 sho is me is me		19a. Informent's Name/Relationship (19			t and Number or R				
6	1 and 2 Haalth em 27 i		Catherine S. B 20e. Method of Disposition	unn	20b. Plece	of Disposition	(Neme of	Hermon		isbury		
Baltimore,	permit. Peges 1 and 2 Department of Haalth of Important: If item 27 is any injury or other tre once.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	cemet	coat	Meth.	. Cem.	7/19/98	Snow		
Bal	Depar Impor any in		21. Signeture of Funeral Service Licer	1300 L	Penni			ess of Fecility Funeral	Home,	P.O. E Snow H		87 ,md.21863
	Di		23a. Part1. Enter the diseese, or comshock, or heart failure. List only	plications that caused one ceuse on each lin	tha death. Do	not enter the	mode of dy	lng, such as cardia	c or respiratory arre	est,	I	Approximata Interval Betwaen Onset and Death
)	Physician /Medical		Immediate Cause (Finel	<i>(</i> : • • •	0/.		/	- acc	- 1			· ·
	Examiner		disease or condition resulting in death)	e. (e)	Due to (or as e			- acc	Ident		-	3min.
	sit ad	iner		h								
	al-tran	Examiner	Sequantially list conditions, if eny, leeding to immediate	U.	Due to (or as a	consequence	e of):					
68760,	ysiciar e buri		Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	c	Due to (or es a	consequence	e of).				-	
89 ×	eath certificate be executed attanding physician and for use es the bunal-transit	Med	resulting in deeth) Lest	ď		3311304301131	5 617.					
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P.O.	t the death by the attar teched for u	hysi	Part II. Other algnificent conditions of	ontributing to death be	ut not resulting	in the underly	ring cause gi	ven in Pert I.	23b. Did to			the cause of death?
	gned b	by P							1011	98 202 NO	3 F10B	abiy 4 Onknown
of Vital Records,	e law requires that hes been signed b ge 2 should be date	Completed							24e. Was a perform	n autopsy ned?	eva	re eutopsy findings illeble prior to apletion of causa leath?
<u> </u>	The ete h	Com							1 □ Ye	s 2 No	1 🗆	Yes 2□ No
Vita	Physiclen: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0.	hor	ath (Check only on			
ō	5 00	. To	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	1 ☐ Inpatie		utpatient 3[Time of	DOA DOA 28c. Inju		fome 5 Reside)
o	Attending ir death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De)		Injury M		rk?]Yes 2□No		,,		
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	Hospital	edical	29a. Certifier (Check only one)	ysician: To the best of niner: On the basis of end manner sta	exemination e	e, deeth occu nd/or investig	irred et the ti ation, In my	me, dete end plece opinion, death occu	e, end due to the ca urred at the time, do	use(s) and man ete and place, er	ner es sta nd due to	ited. the ceuse(s)
	within 2 To the comple	Me	29b. Signature and title of certifler				29c. Licen	se number	25	9d. Date signed	(Month, D	Jey, Year)
			1 Chini	Mahre		_	0	4649	0	2-16	5 - 9	18
,		100	30. Name and address of person who	completed ceuse of de	eath (item 23e)	(Type, Print)	-					
		18	428 W.	MARK	e-F	57	•					

Standing was and the Section of the

Market St. ,

Denton Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

920

32. Registrar's Signature

while will

Sides M.D.

Registrar

State

James

31. Date filed (Month, Day, Year)

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protein Australia (n. 1921) The Adaptive and the second of Threat day was to the St. Commission of the St. St. Commission of the St. St. Commission of the St. St. Commission of the St. Commis

		Please		Print In Blac Maryland /	Depart		lealth and	-	_	23433		
		1. Decedent's Neme (First, Middle, L	ast)					2. Dete of D Month	eeth Dey	3. Time of Deeth		
	Physician /Medical	Ruthanna B. Smit	th					July		.998 6:35 a		
	Examiner	4e Fecility Neme (If not institution, g	ive street and num	ber)		4	b. City, Town, or	Location of Dee	th 4c. County	of Deeth		
		The Memorial		1			Eastor		Talbot			
	Funeral Director	216-18-8333	Sex 1□M 2XF	7. Age (In yrs. lest b		Onths Deys	If Undar 24 Hr. Hours Mir	. (Month, D	irth Ney, Yeer) 12, 1923	9. Birthpleca (Steta or Foreign Country) Maryland		
	iter death with the Maryland items 23s or 28-1 show institute in marking a sub-funeral Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Carol:	ine	10c. City, Tov	wn or Location					10d. Inside City Limits 12 Yes 2 □ No		
	vith the Ma t or 28a-f s be received	10e. Street and Number	-110	00.		Of. Zip Code			10g. Citizen of Whet Country?			
	h wit		eet			21636	5		U.S.A.	A.		
20	0 0 0		Armed For	2₹ No	If Ye	Decedent of His, specify Cube	ispanic Origin? (on, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	Bleck, White, etc.			
8	"natural",	15 Decedent's	Yeer or Da		Doodont	's Usuel Occup	ation		16h Kind of Bu	White siness/Industry		
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Maryland 21215-0020	Mer Mer To	William Baynard 19a. Informent's Name/Reletionship	10	Mary Walls Baynard and Number or Rurel Route Number, City or Town, Steta, Zip Code)								
Ma	tra tra	William N. Smitl					oro Roa			aryland 21636		
0 80 = 1	of He of He r oth	20a. Method of Disposition 1 ☑Buriel 2 ☐ Cremetion 3		20b. Placa		on (Neme of ony or other plea		Dete		City or Town, Stata		
	ortant:	4 Donetion 5 Other (Spec	cify)			o Cemet	-	7/25	Greenst	oro, Maryland		
Bal	permit. Peg Depertment important: If any Injury o	21. Signeture of Funeral Servica Lic	-	yl	721	gle & F	1-16-1-	in Funer	ral Home,	P.A.		
	Physician /Medical Examiner Physician	23e. Fart1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions,	e. P	Due to (or es e	consequer	nce of):	g, such es cardi	ac or respiratory	allest,	Approximate Intervel Between Onset and Death		
Box 68760,	n certificate be anding physicia use es the bur in/Medical											
	the attend for the death	Pert II. Other significant conditions	contributing to de	ath but not resulting	in the under	rlying cause give	en in Pert I.	23b. Die	d tobacco use cor	ntribute to the cause of death?		
S, P.O	es that the death gned by the atte be detached for by Physicia	Serve	, ele	extraly of	e	abno	rmalit	ies 14	Ves 2□ No	3 Probably 4 Unknown		
of Vital Records,	aw requires seen size should pieted							24e. Wa per	is en eutopsy formed?	24b. Were autopsy findings eveilable prior to completion of causa of deeth?		
Œ	The la page page							10	Yes 2 10 No	1 ☐ Yes 2 ☐ No		
ita	ysiclen: The s certificate director, pag	25. Was casa refarred to medical exeminer?					26. Plece of D	eath (Check only	rone)			
7	S o D	1 Yes 2 No	Hospital:	patient 2 ER/C	Outpatient	3□ DOA Oth	er: 4 D Nursing	Home 5□Ras	sidance 6 Oth	ar (Specify)		
ion o	Attending Pt r death. ector: After th by the funera ification:	27. Manner of Death 1 Language State 1 Accident 1 Accident 1 Pending 1 investigati		f Injury , Day Year) 28b.	Time of Injury	28c. Injun Work	y et 28d. Describe how injury occurred k? Yes 2 □ No			red		
Division	is after death. Is after death. In Director: After to the funers to by the funers. Certification:	3 Suicide 6 Could not determine	d 206. Placa	28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)								
	Hospi 4 hou Funer tely fill	29a. Certifier 1 Certifying F								enner es stated. end due to the cause(s)		
	within 2 To the comple	29b. Signeture and title of certifier	the	M	D	29c. Licens	e number	1	29d. Data signed	d (Month, Dey, Year) 23 98		
		30. Name end eddress of person wh Peter Whitesele,		of deeth (Item 23e)			n, MD 21	601				

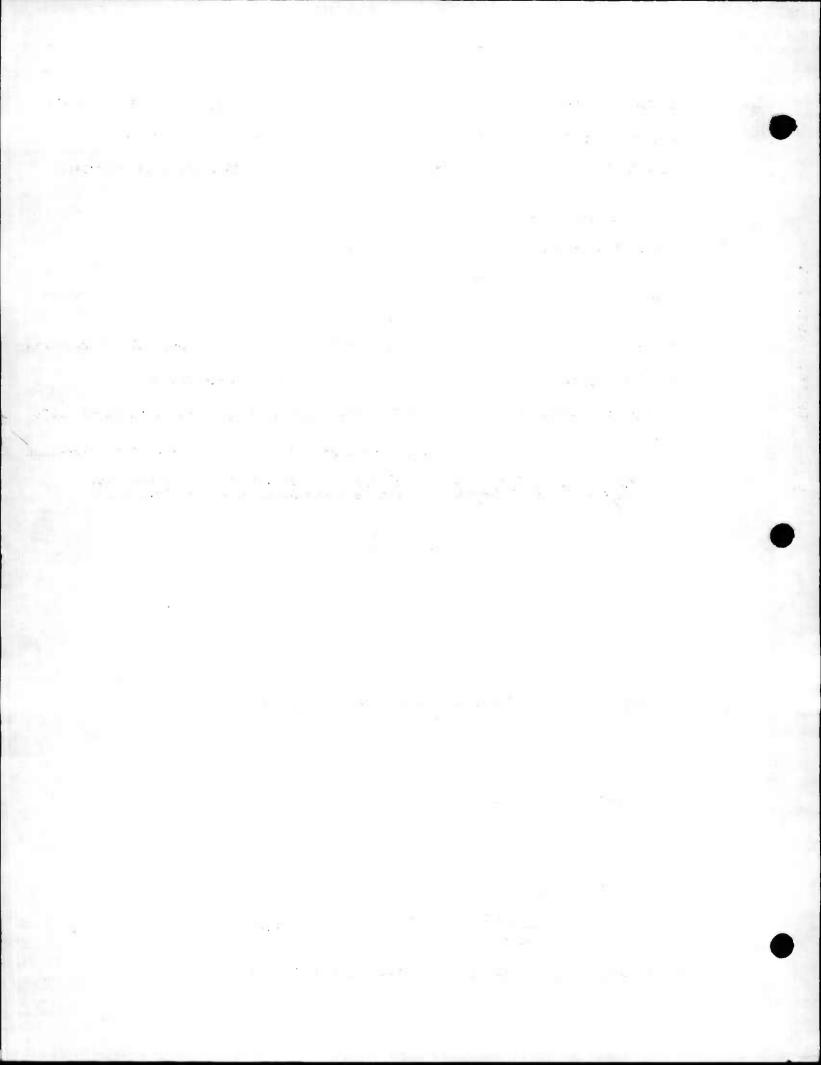
32. Ragistrer's Signetura

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State

Registrar

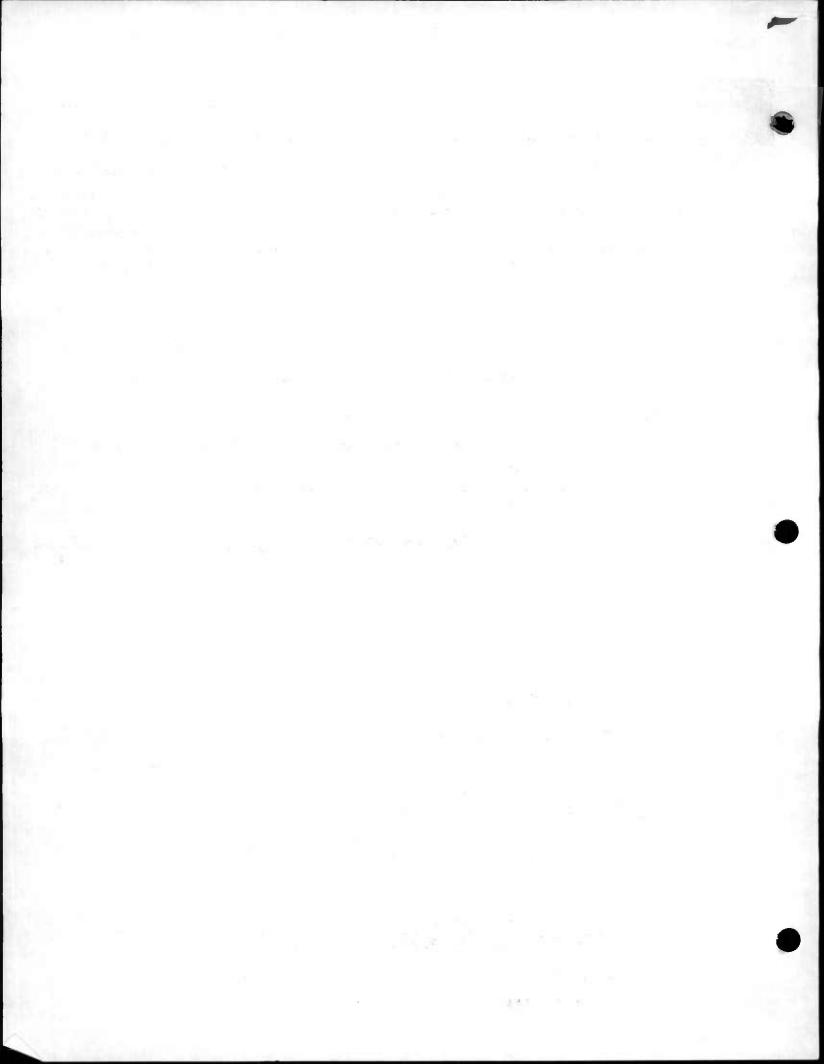
31. Data filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene |

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Physician **EVELYN** LYNHAM SWEET July 17 1998 7:50 a.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year Months Devs If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 X F Deys Hours 215 38 3079 91 Jan. 31, Director 1907 Wash., D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be referenced. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Director Dunkirk 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10701 Ward Road 20754 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☑ Divorced white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementery/Secondery (0-12) College (1-4or 5+) secretary local government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John To Lynham, Sr. Norma Halstead 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Bradley A. Sweet same as # 10 above 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 Removel from State Ft. Lincoln Cemetery 7-21-98 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 het caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, on each line. 23a. Pert1. Enter the disease, or complications shock, or heart feilure. List only one cause Approximete Intervel Between Onset end Deeth **Physician** Due to (or es e consequenca (1): /Medicai Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for usa as the buria law requires that the death certificate be Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 10 3 Probably 4 Unknown 2 erosclesosi's 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peen Jas certificata 2 100 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medicat exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 □ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 ANaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1/ Defitying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) Sam Tellwa, M.D. Clinton, MD 31. Dete filed (Month, Dey, Year) 32. Registraris Signature State Julia Davidson Rardall Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month July 8 1998 4c. County of Deeth 1330 18 Eva Elizabeth Taylor 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days 1 M 2 X F 96 214-74-4109 10/19/1901 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Pocomoke City Worcester 10e. Street end Number 10g. Citizen of Whet Country? 2431 Tulls Corner Road 21851 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Baca - American Indian 11. Maritel Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry

d 2 should be filed within 72 hours efter death with the Marylen th end Meniel Hygiene.

7 is marked other than "naturel", or items 23s or 28s-f show treurnetic event, the Mexical Examinet must be notified at Funeral Baltimore, Maryland 21215-0020 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Housewife 8 permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, Important: If Nem 27 is merked othe any injury or other treumetic avanta 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Charlie Christopher Ball Bertha Florence Brewington 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John Taylor / son 2431 Tulls Corner Rd., Pocomoke, MD 21851 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date **X**☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Nelson Cemetery 7/21/98 Pocomoke, MD 22. Name end Address of Fegility Holloway-Melson Funeral Home 21. Signeture of Funeral Service Licensee ADean Muc 103 Linden Ave., Pocomoke, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediete Ceuse (Final diseese or condition resulting In deeth) /Medical Examiner certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

Physician/Medical Examiner attending physicien and for use es the buriel-trans thet initieted events resulting in death) Lest

Physician

/Medical

Examiner

Director

10a. Stete

Funeral

Director

the Marylend

Approximete Intervel Between Onset end Deeth Due to (or es a consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Domestic

20c. Location - City or Town, Stete

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

2 No 1 Yes 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 212 No 1[] Yes

Hospitel: Inpatient

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA

26. Place of Deeth (Check only one)

27. Manner of Death

Dete of Injury (Month, Dey Year)

2 ER/Outpetient 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rure! Route Number, City or Town, State)

29a, Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date and plece, end due to the ceuse(s) and manner steted.

29b. Signeture and title of certifier

31. Dete filed (Month, Dey, Year)

29c. License number

29d. Date signed (Month, Dey, Yeer)

3

State Registrar

32. Registrer's Signeture 2 0 1998

-vaeu

Splin Davidson

pleted cause of death (Item 23a) (Type, Print)

signed b

After this certificete funeral director, pag

Director: /

within 24 hours eff To the Funeral DI completely filled in Hospital

Be

2

Certification:

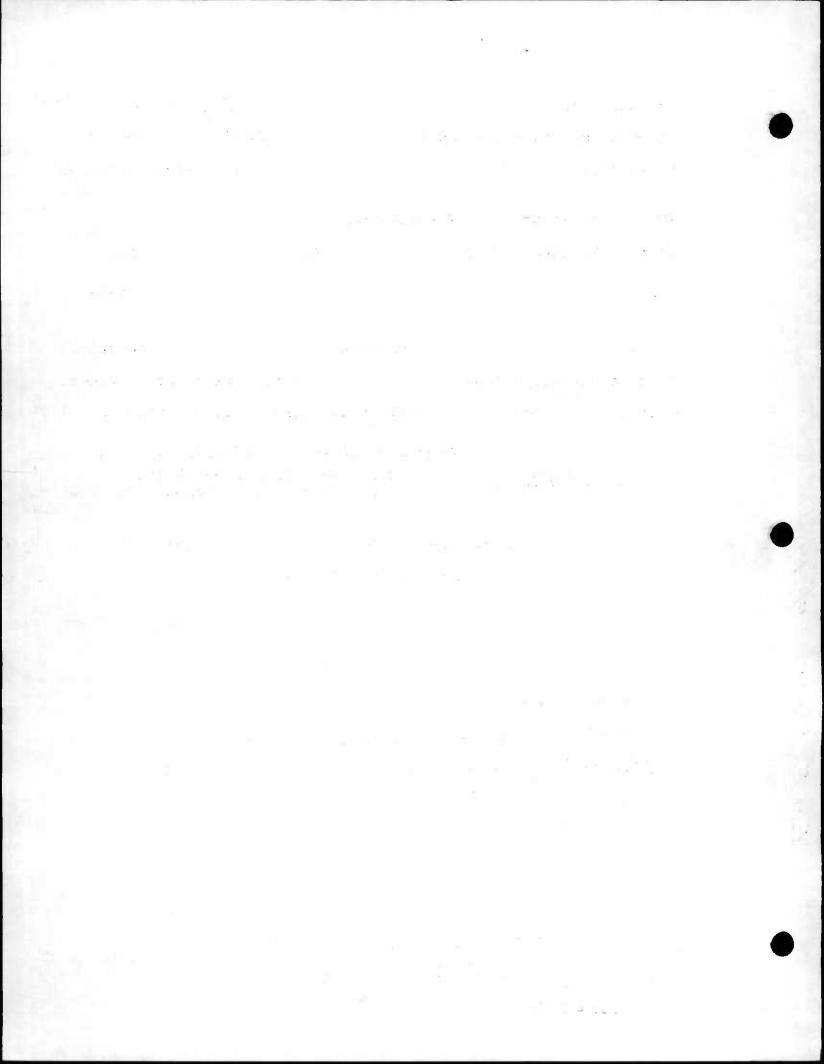
cal

Med

Division of Vital Records,

or Attending Physicien:

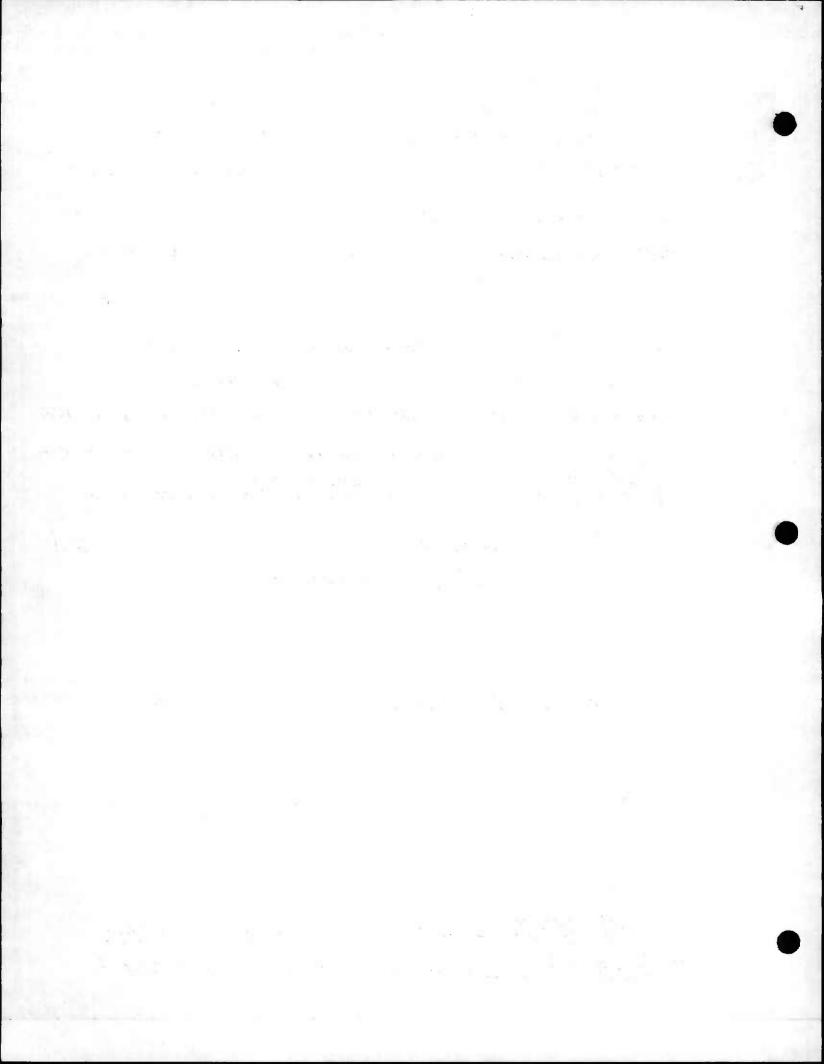
death.



State of Maryland / Department of Health and Mental Hygiene

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					Cei	rificate	ot i	Death		1	Reg. No.		
Physi /Med	cian dical	Decedent's Name (First, Middla, L Ray	Sa	nuel		Т	0 W E	RS		Data of Dea Month U L Y	Day	Yaar 1998	3. Tima of Death 7:00 A
Exan		4a. Facility Nama (If not institution, go SHORE NURSING			TION	CTR.	4	· ·	wn, or Locati NTON	ion of Daath	,	of Death	
Funera Directo	_	5. Social Sacurity Number 6. 220–12–0072		7. Age (In yrs. la:		If Under 1 Months	Yaar Days	If Under 2 Hours	Min.	Date of Birt (Month, De gust 14	th y. Yeer) 4, 1918	9. Birthpia Country Maryl	ce (Stata or Foraign) Land
eryland show	_	Usuel Rasidance of Dacedant 10a. Stata 10b. County			Town or Lo							100	I. Insida City Limits 1 ☑ Yas 2 ☐ No
the M	Director	Maryland Caroli	ine	Ri	dgely	10f. Zip C	oda.				10g. Citizan of N	What Country	
3a or	ă		11 Donal				1660	2			United		
and 21215-0020 be filed within 72 hours after death with the Meryland tial Hygiene. d other then "natural", or items 23s or 28s-f show event, the Med cal Examiner must be notified at	d by Funeral	13049 Crouse Mi 11. Marital Status 1 Nevar Married 2 Marriad 3 Widowed 4 Divorced		2⊠No a									Indian,
72 h	Completed	15. Dacedant's E (Specify only highast g			16a. Daced (Give	dant's Usuai kind of work DO NOT usa	Occup dona	ation during most	t of working		16b. Kind of B	usinass/Indu	stry
within within iene.	E	Elamantary/Sacondary (0-12)	Coliaga (1-	-4or 5+)									
DO .		10 17. Fathar's Nama (First, Middla, Las	*)		Farme	er/Liv	e S		Hauler		Farmin Maidan Suman		
Maryland 2 d 2 should be filed th and Mental Hygin 7 is marked other traumatic event, it	To Be	Otis 7	Towers		20.00			Edna	a Me	eridit	h		
		19a. Informant's Name/Relationship (Type, Print) 19b. Maiiing Address (Street and Number or Ru								ural Routa Number, City or Town, Stata, Zip Coda)			-
ロヨペト		Ann S. Towers 20a. Mathod of Disposition	WIL	_		sition (Name		MITIT		Data	20c. Location		
Daltimore, pemit. Pages 1 e Department of Her Important: if item any injury or othe		1 Surial 2 Cramation 3 4 Donation 5 Other (Spec		Stata	na <i>tary</i> , crar	natory or oth	ar plac			7/98			Maryland
h certificate be executed Examine and model and the principle of the prin	1	Immadiate Causa (Final diseasa or condition resulting In death) Sequentially list conditions, if any, leading to immadiata ceuse. Enter Undarying Causa (Diseasa or injury that initiatad avants resulting In death) Last	a. S b. ay	Dua to (or a	as a consec	quance of):	re,	me	e				2d.
o death	SICI	Part II. Other algoriticant conditions	contributing to dea	ath but not result	ing In tha u	ndarlying cer	usa giv	an in Part I.		23b. Dld 1	tobacco use co	contribute to the cause of death?	
igned by the e	by Phy	alzheemi	is d	emen	tea					1 🗆	Yes 2000	3 Proba	bly 4 ☐ Unknown
aw requires been seen seen seen seen seen seen se	Completed b			J. N.							an autopsy mad?	avaii	a eutopsy findings ebie prior to pletion of cause eath?
ysician: The l ysician: The l s certificate he director, page	Son									1 🗆 🗅	ras No	10	Yas 2□ No
VICAL Mician: The certificate rector, pag	Be	25. Was cese referred to medical examiner?							of Death (C	heck only o	na)		
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To	1 Yes 2 Oo 27. Mannar of Deeth ↑ Raturai 5 Pending 2 Accidant invastigatic	28a. Deta o (Month	•	R/Outpatier 8b. Tima of Injury		c. injur	4100000	28d		dance 6 Oth		
LIVISION Ital or Attanding irs after death. al Director: After lied in by the fune	Certification:	3 ☐ Suicida 6 ☐ Could not l 4 ☐ Homicida datermined	288. Place of buildin	of Injury - At hom g, etc. <i>(Spacify)</i>		100				City or Tov			
Hospl 24 hou Funer etely fil	edicai	29a. Certifiar 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the t miner: On the ba- and mann	sis of examinatio	edga, daath n end/or in	occurred at vastigetion, i	the tin	ne, date end pinlon, deat	d piece, end th occurred a	due to the	ceuse(s) end mo data and place,	enner es stat and dua to th	ad. ha cause(s)
To the within To the	Me	29b. Signatura and title of serullar	a	_ m.	0		-	a number	284		29d. Data signe	d (Month, De	ay, Yaar)
		A Harris of person who	compiated ceuse	of death (Item 2	(3a) (Typa,	Print)				no	2/60)/	
S	tate	31. Data filed (Month, Day, Year)		gistrar's Signatu	-6	john						V	



State of Maryland / Department of Health and Mental Hygiene 98

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					Cei	rtificate	e of	Death		Re	g. No.				
Dhysisis	_	1. Decedent's Name (First, Middle, I	Last)		77					2. Dete of Death	1	Year	3. Time of Dee		
Physiciar /Medica	_	BERTINA	MODE N		WEEMS				_		_	998	2:45		
Examine		4e. Fecility Neme (If not institution, g 610 Camp Canoy		nber)]	usb			alvert			
Funeral Director		215-70-7749	Sex 1□ M 2ĀF	7. Age (In yrs. {	last birthday) 35 Yrs.	If Under Months	1 Year Deys		Hrs. Min.	8. Dete of Birth (Month, Day, Sept. 28	, 1912	9. Birthple Country Mar	ce (Stete or Fo. y) y1and		
*	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						100	d. Inside City Lie		
aba	٥	Maryland Cal	vert			Lusby						100	1 ☐ Yes 2		
23a or 28a-f show	Funeral Director	10e. Street end Number 610 Camp Cano				10f. Zip	Code 206	57		10	g. Citizen of N		y?		
8 23 mail	era	11. Meritel Stetus		dent Ever in U	C 121	Man Doord			n? (Specify Ves or No. 14			USA 4. Rece - American Indien,			
fine. The first of terms 23a of 28a-f show The Medical Experiment must be notified at	by Fun	1 Never Merried 2 Married 3 ₩ Widowed 4 Divorced	Armed Fo	ces? 2 [Ž.No 9				of Hispenic Orlgin? (Specify Yes or N Zuben, Mexicen, Puerto Rican, etc.) No Specify:		ican, etc.)		ck, White, et	c.		
natural rolical Ex	Completed by	15. Decedent's (Specify only highest of	Education		16e. Deced	dent's Usuel	Occup	petion during most o d)	workin	1	16b. Kind of Business/Industry				
e an	ğ	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT us Dusewi		d)	WOIAII		Own Home				
1 Page 1 1 3	ဂ္ဂ	17. Falkada Nama (First Atiddle I a			пс	Jusewi	rie	40.44.11.11		Own Home (First, Middle, Melden Surneme)					
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557		19e. Informent's Neme/Relationship Charles Weems/Sc						end Number		Route Number, Bby, MD	City or Town, State, Zip Code) 20657				
9 = 2		20e. Method of Disposition 1		Stete	Plece of Disponentery, cremetery, cremetery	netory or of	her ple		7/	Dete 2 24/98	Oc. Location -	City or Tow	n, Stete		
Depertment Important: any injury conce.		21. Signeture of Funerel Service Lic	ensee T. Serre	N				ss of Fecility Beach		ell Fun Prince			MD2067		
wedical state buriel-transit and see so the buriel-transit and see so the buriel-transit and see see the buriel-transit and see see the buriel see see the buriel see see the buriel see see the buriel see see the buriel see see see see see see see see see s	Aedical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	e. Pina b. Dia	Due to (o	r es e conseq r es e conseq r es e conseq	juence of):									
tendii or use	any		d									!			
hed for	Physician	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given								23b. Did tob	acco use co	ntribute to t	he cause of de		
een signed by the ettenhould be detached for u	oy ru							1□Ye	s 2□No	3 Proba	bly 4 X Unk				
2 8 5										24e. Wes en perform	eutopsy ed?	evell	e eutopsy findin eble prior to pletion of cause eth?		
ector, pega	0									1 ☐ Yes	2 No	10	Yes 2□ No		
certificate rector, peg		25. Wes case referred to medical exeminer?							Deeth	(Check only one)				
w 5 2		1 Yes 2 No		patient 2 🗆			^		-	e 5 Resider		- ' ' ' ' ' '			
2 6 6	LO	27. Manner of Death 1 ☑Neturel 5 ☐ Pending 2 ☐ Accident Investigeti	28e. Dete of Injury 28b. Time of Injury 28c. Injury et Work?						20	28d. Describe how injury occurred					
or: After	100	Z C / tooldont	3 Sulcide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)							e 28f. Location (Street and Number or Rural Route N City or Town, State)					
atter death. al Director: After ed in by the fune	Certificat	3 ☐ Sulcide 6 ☐ Could not	be 28e. Piece building	g, etc. (Specif											
o Funeral Director: After tietaly filled in by the funeral Certification:		3 Sulcide 6 Could not determine 29a. Certifier 1 Certifying F	289. Piece buildin	pest of my kno-	wledge, death	occurred e	t the tir	me, dete end p plnion, deeth	lece, er	nd due to the ce	use(s) end me te end place,	enner es stet end due to ti	ed. ne ceuse(s)		
within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun Medical Certification	redical	3 Sulcide 4 Homicide 29a. Certifier (Check only) 2 Medical Exp	28e. Mece building Physician: To the aminer: On the ba	pest of my kno-	wledge, death	occurred e	t the tir	me, dete end p plnion, deeth se number	elece, er	d et the time, da	use(s) end me te end place, ed. Dete signe	end due to ti	ne ceuse(s)		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | |

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XXII	(127)	00

Item: 10c per F.H. G-762 8/3/98 reb 1. Decedent's Name (First, Middle, Last) Anderson

Certificate of Death

3. Time of Death

5:03P.M.

10d. Inside City Limits

P	hy	/si	cia	n
			lic	
E	Xi	am	ine	H,

2505 MANHATTAN AVE 5. Social Security Number

1 M 2 □ F

N/A

Edna

4a Fecility Neme (If not institution, give street end number)

75

7. Age (In yrs. last birthday) Months Deys Yrs

BALTIMORE If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year 23 Hours

4b. City, Town, or Location of Death

2. Dete of Deeth Month

JULY

9. Birthplece (State or Foreign Country) Mass

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiane. Improchant: If item 27 is marked other than "netural; or items 23e or 28e-f show any injury or rother traumate event, its Menical Experiment must be notified any injury or other traumate event, its Menical Experiment must be notified as 급 Funeral ģ Completed

Be

3altimore, Maryland 21215-0020

Usual Residence of Decedent 10a. State Md 10e. Street end Number

219-12-5184

10c. City. Town or Location BALTIMORE Manhattan 10f. Zip Code

1 ¥ Yes 2 □ No 10g. Citizen of Whet Country?

16b. Kind of Business/Industry

USA

1998

4c. County of Deeth

30,

2505 Manhatan 11. Marital Status

12. Wes Decadent Ever in U,S. Armed Forces? 1 Yes 2XX0 If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 3√Widowed 4 □ Divorced

 Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2☐No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 8th grade

College (1-4or 5+) N/A

Avenue

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Laborer

21215

Catholic School

17. Fether's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame) Edna Palmer

Ross Roberts

19e. Informant's Name/Relationship (Type, Print) Michael Anderson- Son

8834 Allenswood Road

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown, Md 2113B

20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

) am

20b. Placa of Disposition (Name of cemetery, crematory or other place)
King Memorial Park

20c. Location - City or Town, Stete 8-3-98 Randallstown, Md

21. Signeture of Funeral Service Licenses

e a

22. Name and Address of Facility March F/H West

Md 21215 4300 Wabash Avenue Baltimore, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Physician /Medical Examiner

The lew requires that the death certificate be executed

n signed by the a

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After this certificate funeral director, peg

ector:

in 24 hour. the Funeral Direction

To the Hospi within 24 hou To the Funer completaly fil

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Attending P Division

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Completed

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Certification:

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Records, P.O. Box 68760.

Vital Physician:

of

Immediate Cause (Final disease or condition resulting in death) Physiclan/Medical Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Arteriosclerotic Cardiovascular Disease Due to (or as e consequence of)

Due to (or es a consequenca of):

Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Wes en eutopsy performed? INSPECTION

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

Approximate Intervel Between Onset end Deeth

1 Tyes 20XNo 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1X Yes 2□ No

27. Manner of Deeth 5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 | Inpatient 2 | ER/Outpetient 3 | DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

29a. Certifier

1 X Naturel

2 Accident

3 Suicide

4 I Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as stated.

Medical Exeminer: On the bests of examination end/or investigetion, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

JULY 31,1998

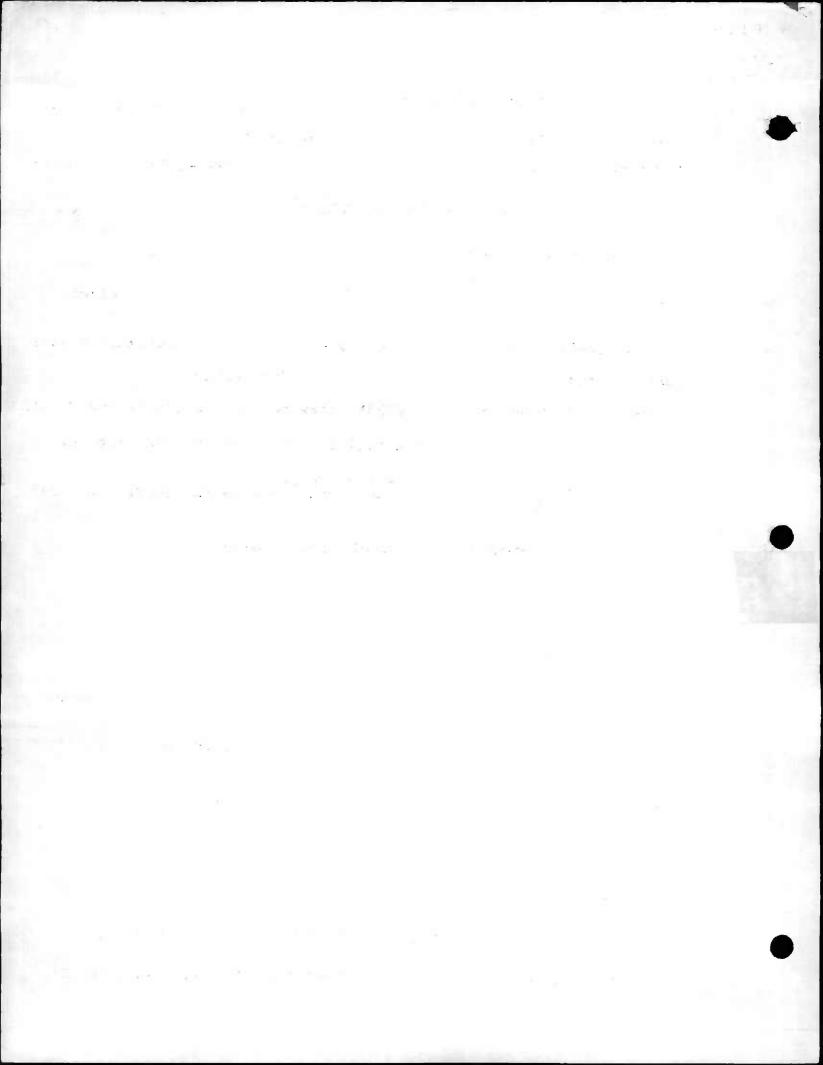
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Stephen Radentz, M.D. 31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201 82 Registrar Stonature

State Registrar



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month ACKERLE' 1:30 P Wayne July 28 DOUGLAS 1998 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore HOPKINS HOSPHAL CITY Johns If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Hours Months Days 1₽M 2□ F Yrs. 468-68-2372 46 July 16,1952 Minnesota Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 □ No Md. Baltimore Randallstown 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 4112 Tiverton Road 21133 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Plant Manager London Fog 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Albert Wesley Ackerley LaVonne Faye Kleidon 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4112 Tiverton Road; Randallstown, Maryland21133 Mrs. Lori Ackerley 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremetion 3 Removal from State Baltimore/Washington Crem. 7/30/98 Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road; Randallstown, Md. 21133 23a. P vt1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, show the heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel Stroke 30 minutes Probable Due to (or es e consequence of): Due to (or es a consequence of)

Physician /Medical Examiner

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> > page 2

818 director,

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Attending

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Certification:

Medical

certificate be same

Division of Vital Records, P.O. Box 68760,

Physician

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Director

Funeral

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Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

disease or condition resulting In death) Examiner physician and a the burisi-trans Physician/Medical 8

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest

Due to (or es e consequence of)

Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert 1. renal

23b. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings eveilable prior to completion of cause of deeth?

2□ No

1 ☐ Yes 2 No

Baltimore Md 21205

25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner stated.

600 N. Wolfe

29b. Signature end title of certifier

29c. License number

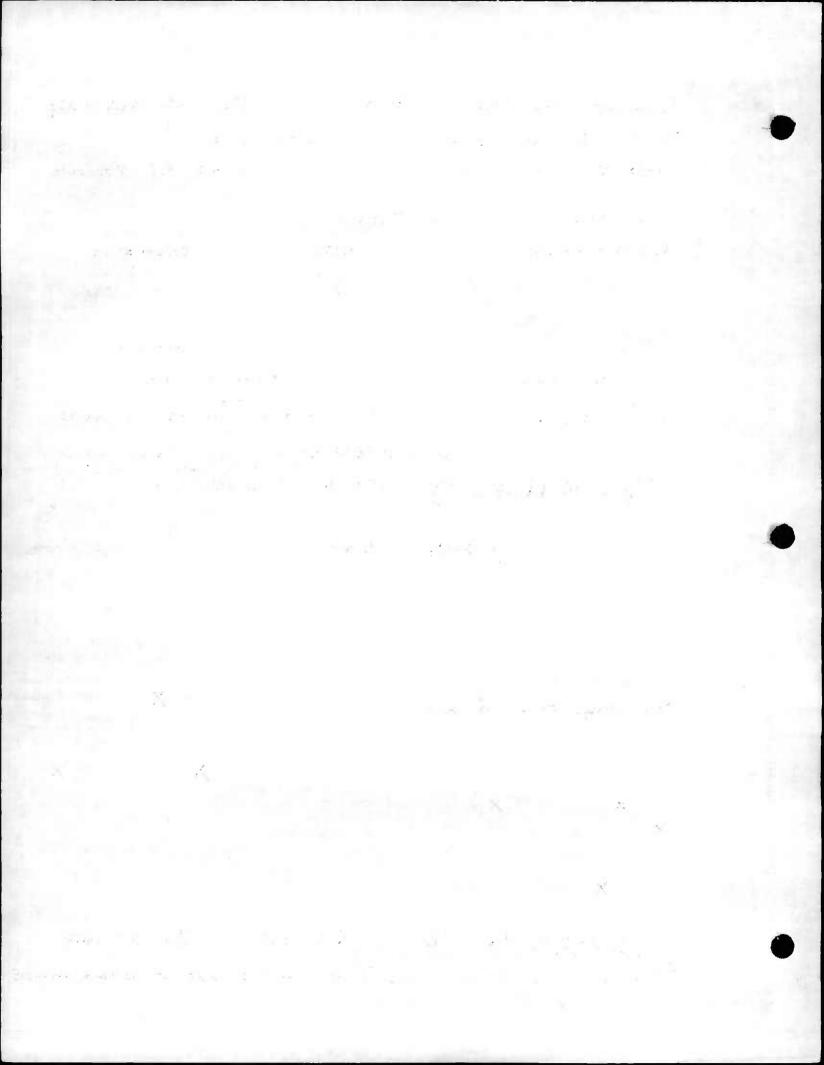
29d. Date signed (Month, Dey, Year)

St.

30. Neme address of person why empleted cause of death (Item 23a) (Type, Print)

Brandon Bankowski MID lower 1 32. Registrar's Signature
Tuna Davidson-Randage

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3 Time of Death 2. Data of Death Month Novena Maria Barnes July 4c. County of Death 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04/07/1951 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) Maryland 213-54-2525 Months 1□ M 2Ø F Usual Rasidence of Decedent 10b. County 10c. City. Town or Location 10d. Insida City Limits Baltimore n/a 1 ☑ Yas 2 ☐ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 2009 Deering Ave. 21230 United States 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Bleck, White, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2 ☑ Married Specify: White 1 ☐ Yas 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Own Home 10 Housewife 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Helen Golden John Frederick 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) James Edward Barnes, Sr 2009 Deering Ave. Baltimore, MD 21230 James Edward Barnes, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stete Hill Cemetery 8-4-78 Brooklyn, Mary 49-00 22. Name and Addrass of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Servica License 23a. Part1. Entar the disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heer feilure. List only one ceuse on each line. Approximata Intervel Between Onset and Daath Immediate Causa (Final disaasa or condition rasulting in death) Aspiration Forty Minutes Dua to (or as a consequence of): longestive Heart 1992 -Obstructive Pulmonary Disease Chronic Dua to (or as a consequence of) Renal Chronic Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Wiceis 24b. Wara autopsy findings aveileble prior to completion of causa of death? In farction 24a. Was an autopsy performad? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

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ortant: if item 27 is marked other than "natural", or items 23s or 28s-1 show injury or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter Department of Heelth end Mantal Hygiena. Introcrant: If them 27 is merked other than "natural", or iter any injury or other traumatic event

3altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Burnes, Novena

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Examine To the Hospital or Attending Physician: The law requires that the castin certainant within 24 hours effar death.

To the Funarai Director: Affar this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be datached for use as the burial-transit Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Diseesa or injury Physician/Medical that initiated avants rasulting In death) Last

29b. Signatura and titla of certifian

John

Completed Myocardial Be 25. Was casa rafarred to medical 26. Pleca of Daath (Check only ona) axeminar? Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Spacify) 2 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Mangar of Daath 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be dataminad 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 ☐ Homicida 18 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian Medicai

29c. Licansa number

29d. Data signed (Month, Dey, Yaar)

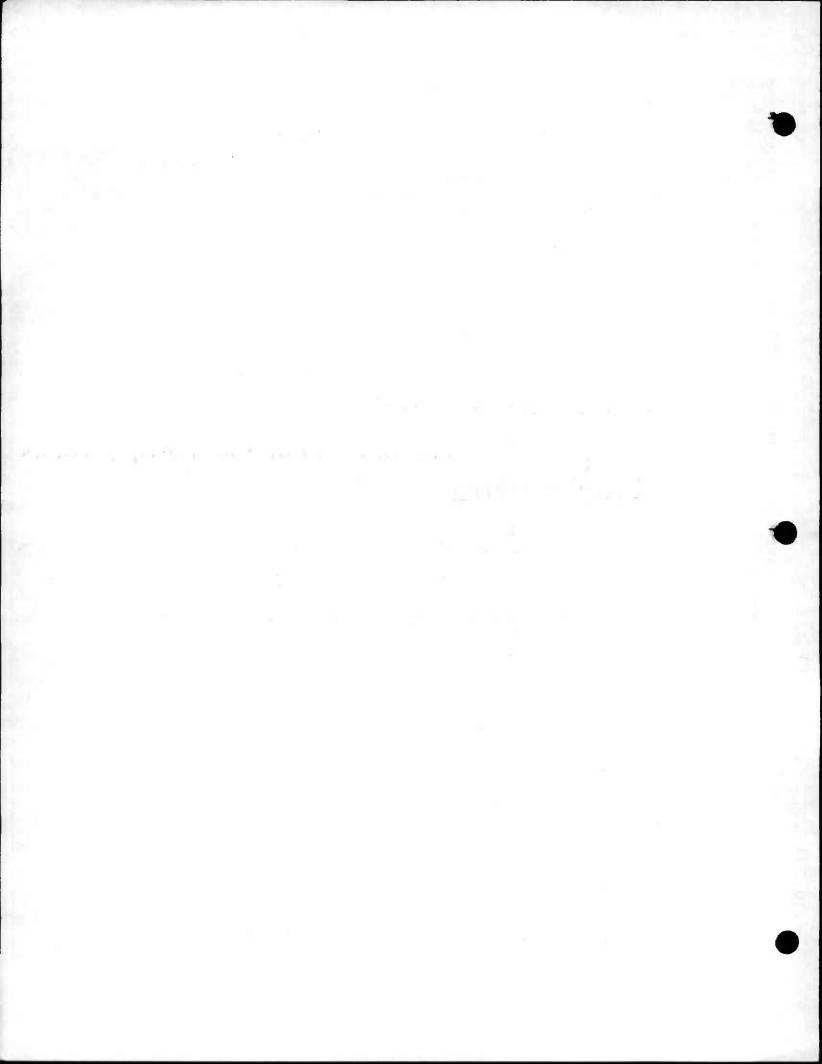
State

Registrar

900 31. Data filed (Month, Day, Year) 32. Registrer's Signetura

30. Neme and address of person who completed causa of death (Itam 23a) (Type, Print)

Coton Avenue Baltimore MD 21229 Julia Davidson Bandalle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Dey Yeer Month Frank James Buniff 30 4c. County of Death 15 A.M Jul 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, giva street end number) Glen Burnie North Arundel Hospital Anne-Arundel 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 6. Sex Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) Days Hours **★**M 2□ F Yrs 219-07-2006 88 April 14,1910 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes % No Md Anne-Arundel Glen Burnie, Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 Marie Avenue 21060 United States 12. Was Decedent Ever in U.S. Armed Forces? Nav 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Bleck, White, etc. Navy 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 43-45 Specify: White XX Widowed 4 Divorced 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Manufacturing N/A Brewer 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) James R. Buniff Emma Mae Saunders 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Margaret E. Saia / Daughter 132 Marie Avenue Glen Burnie Maryland 20b. Plece of Disposition (Neme of cematery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 120 urial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Crownsville veterans cemetery August 3, 1998 Crownsville, MD Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complication that used the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Deeth Emplysen Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of): Heary forthe Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last De to (or as a consequenca of) Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Reubitmo 24b. Were autopsy findings available prior to 24a. Wes en eutopsy completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medicel examiner? 26. Piece of Death (Check only one) Hospital: Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 No 1 inpetient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medical Examiner The law requires thet the death certificate be executed attending physician end for use as the burieffra P.O. Box 68760. s been signed by the should be detached Division of Vital Records. p Completed nis certificate hes to il director, page 2 s Attending Physician: Be Certification: To this funeral After death.

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f ehow Exansiser must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23 any Injury or other traumatic event, the Medical Examiner must

Physician

/Medical

Examiner

Director

Funeral

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the Maryland

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To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

State Registrar

edical

29a. Certifier (Check only one)

29b. Signaturand title of 21

31. Date filed (Month, Day, Year)

AUG

29c. License number

Text Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29d. Dete signed (Month, Dey, Year) 30,1990

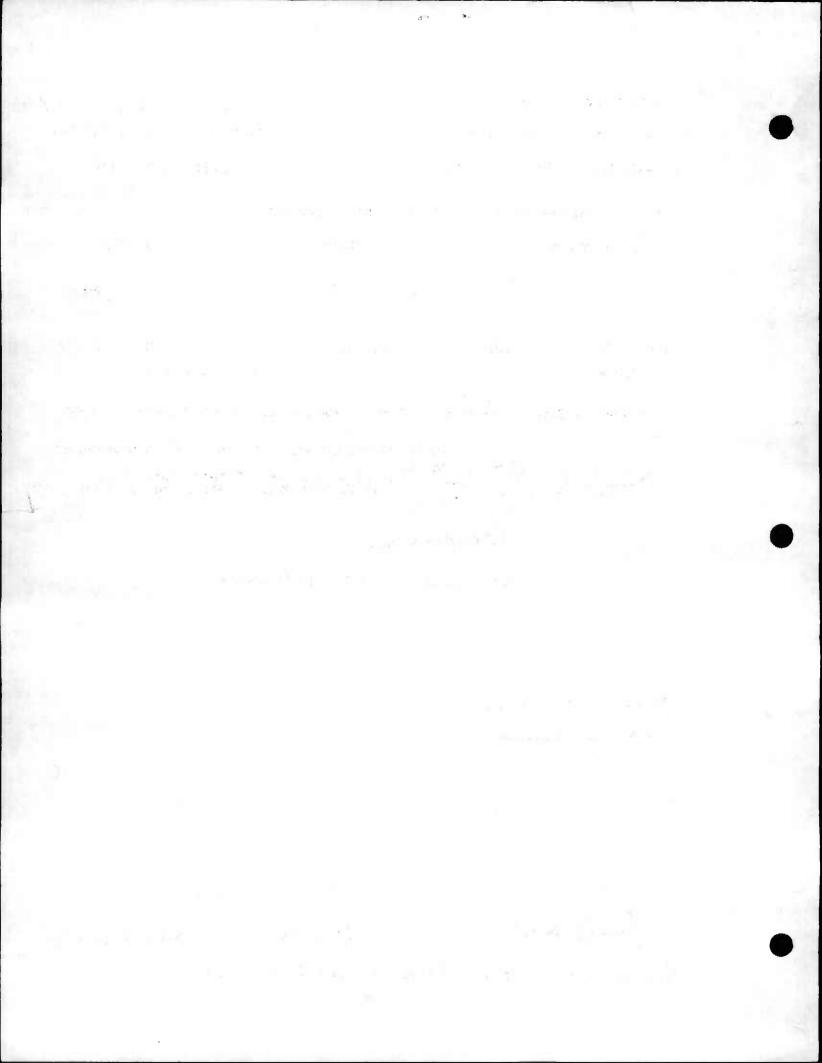
Name and address of person who completed cause of death (Itam 23e) (Type, Print)

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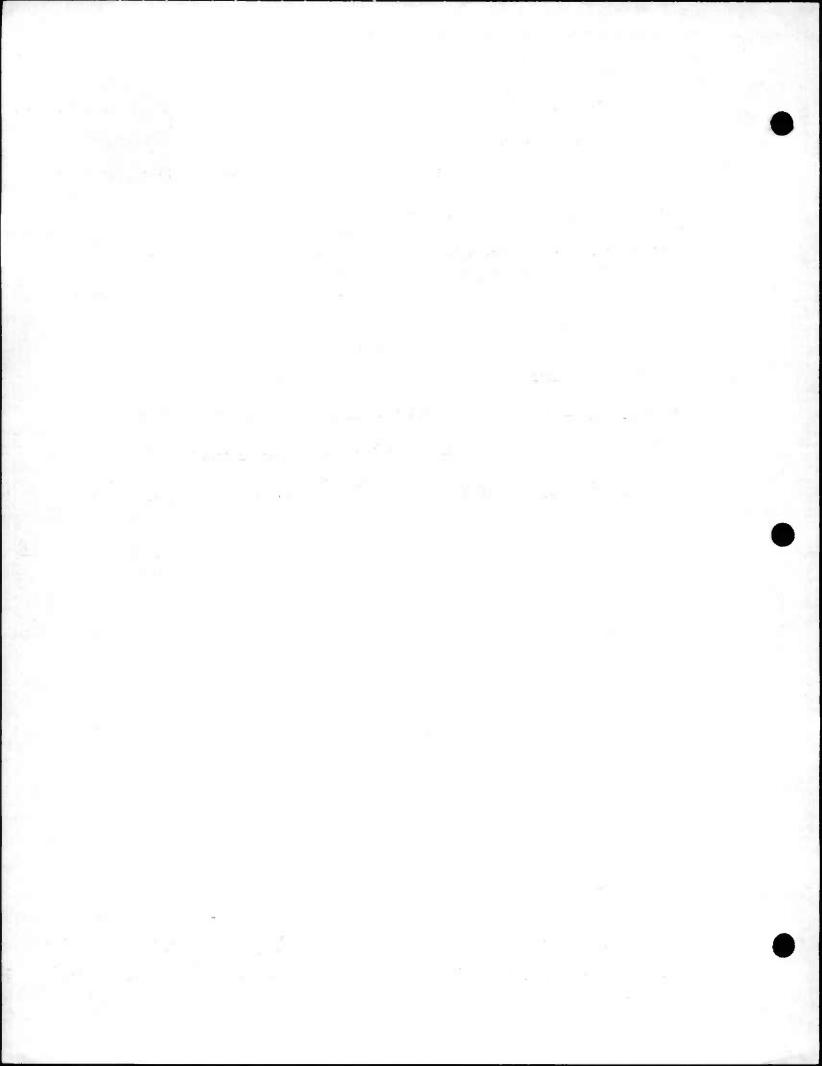
Applical Hrundel 32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene 🔾 🔿

	÷	Decedent's Nama (First, Middle	, Last)		C	ertificate o	r Death	2. Data of Dea	Reg. No.		3. Time of Death
Physici		Lois Ellen 1	Burgee					July	Dey 30 1	Year 1998	10:38 PM
/Medic Examin		4a. Facility Nama (If not Institution		er)			4b. City, Town, or	Location of Death			10.30 FM
	-	5400 Vantage 1	Point Road				Columbi	a	Hov	Howard	
Funeral Director		5. Social Sacurity Number 216–14–0461	6. Sax 1□ M 2\ F	Aga (In yrs. 91	last birthda Yrs.	Months Day			h v, Year)	9. Birthple	aca (Stata or Foraign ry) ahoma
pu *		Usual Rasidance of Decedant 10a. Stata 10b. County		100 Cit	y, Town or	continu					
ne Marylan 8a-f show ziff ed at	ctor	MD Howa	ard		lumbi					10	d. Insida City Limits 1 ☐ Yas 2 🏋 No
ath with the Mary 23s or 28s-f sh	Funeral Director	10e. Street and Number 5400 Vantage Po	oint Road,	FOAL.		10f. Zip Code 21	044		10g. Citizan of W USA	/hat Count	ry?
ter de Items	þ	11. Marital Status 1 □ Nevar Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	Armed Forca 1 Yas 2 If Yes, Giva	2. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (It Yas, specify Cuban, Maxican, Pua 1 ☐ Yas 2 ☐ No Specify:			Specify Yas or No- to Rican, atc.)	14. Race Biacl Specify:	- Amarica k, Whita, a Whi	tc.	
72 hours	Be Completed	15. Dacedant (Specify only highas	s Education	ation 16a. Do		edant's Usual Occ	upation na during most of wo	orkina	16b. Kind of Bu	siness/indu	ustry
2121 d within giene. r than	du	Eiamantary/Secondary (0-12)	Collaga (1-4c	or 5+)	1						
nd 212 e filed with al Hygiene. I other then went, the	Ö	12 Cathada Nama (Cinat Middle)	5+		Frem	entary Te		4771	Educat		
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hygiene. 71s marked other than "natural", or traumatic event, the Medical Exam	To Be	17. Fathar's Nama (First, Middla, I Oscar Wilburn N	lontgomery					ma (First, Middla, lice Bufo		a.)	
, Maryle and 2 should eith and Mer 27 is marke er traumatic		19a. Informant's Name/Ralationsh Michael Burgee	ip (Type, Print) (Son)	19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, 3280 Melrose Lane, Keswick, VA 22947							Code)
Baltimore, Marylan permit. Pages 1 end 2 should be popartment of Heelth and Mental important: If Item 27 is marked of any injury or other traumatic even once.		20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Nama of cematary, crematory or other place) Linden Hills Cem. 20c. Location - City Frederick,								•	
Baltin permit. Ps Department important any injury once.		21. Signature of Funaral Sarvice L	icensaa	,	1		rass of Facility uneral Hor	mes Inc.			
		23a. Part1. Entar the disease, or shock, or heart failure. List of	complications that caus	sed the deat	h. Do not a	nter the mode of d	N Knolls I	c or respiratory ar	mbia, M		1045 Approximata
Physician /Medical Examiner	ler	Immedieta Causa (Final disaesa or condition rasulting in death)	a. Al	24	lyn	equance of):	Dseu			3	Interval Batween Onsat and Death
Box 68760, leeth certificate be axecuted attending physician and 1 for use es the burlel-transit	VMedical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last	b	Due to (or as a consequence of): Dua to (or as a consequence of):							
dS, P.O. BOX ires thet the deeth cert signed by the attendin d be detached for use	Physician/	Part II Other circlificant can differ			data to the			1 001 044			
o the state	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							the cause of death?		
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aw requ	Completed b							24a. Was a	an autopsy mad?	com	ra autopsy findings liabla prior to apletion of causa aath?
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of Vita Physician: this certific ral director,	10	axaminar? 1 ☐ Yas 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2	ER/Outpati	ent 3 DOA	Whor	Homa 5 ☐ Rasid		r (Specify))
		27. Mannar of Death 1 Natural 5 Pending 2 Accidant Invastigi		ojury Da <i>y Year)</i>	28b. Tima Injury	W		_	ow injury occurre		
of of or	Certification:	3 ☐ Suicida 6 ☐ Could n 4 ☐ Homicida data mii	and 288. Place of I	Injury - At ho atc. (Specify	oma, farm, s	traat, factory, offic	9	28f. Location (S City or Tow	itreet and Numbern, Stata)	er or Rurai	Routa Number,
Tood A your	edical C	29a. Cartifiar (Check only one) 12 Sertifying 2 Medical E	Physician: To the best xaminer: On the basis and mannar	ot exeminal	wladga, dae tion and/or	th occurred at tha nvastigetion, in my	tima, data and place opinion, deeth occi	e, and dua to the c urred et the tima, c	ausa(s) and mar data and plece, e	nner as sta and due to t	ited. the ceuse(s)
To the comple	Me	29b. Signatura and titla of certifier	7			29c. Lice	nse numbar		29d. Data signed	(Month, D	ley, Year)
		Willen 7	lums			12	0789		JULY	31	1998
4		30. Nama and addrass of parson w	the completed cause of	death (Item	23a) (Typo	55 Latt	h Pul	beent	Colm	nbu	c ms
Stat Registra	-	31. Data filad (Month, Day, Year) AUG 3 15	98 32. Regis	strar's Signa	tura Aan	dell					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Jessie F. Braganza JULY 19, 1998 9:26 PM 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital Baltimore N/A If Under 24 Hrs. Hours Min. If Under 1 Months 8. Dete of Birth (Month, Dey, Yeer) July 3, 1926 5. Sociel Security Number Birthplace (State or Foreign Country) Indla 7. Age (In yrs. lest birthday) 213-98-532 72 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Elkridge Yes 2□No 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 6218 Summer Home Terrance 21075 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Records Manager Law 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Vincent Soares Unavailable 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Philomena D'Souza/Daughter 6218 Summer Home Terrance, Elkridge, MD, 21075 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Pk. 7/24 Elkridge, Maryland 21. Signature of Funeral Service License 22. Neme end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge Mem.Pk 7250 Wasington Blvd, Elkridge, Maryland, 21075 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart failure. List only one cause on each line. acute myocardial Immediate Cause (Final disease or condition resulting in death) MALVIDUM Due to (or es e consequence of): Cardiovascular disease Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest mellitus Due to (or es e consequence of) Pert II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 3 Probably 4 ∭Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 NO 2/ No 1 Yes 1 Yes 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 PR/Outpatient 3 DOA 27. Menner of Deeth 1 Naturel 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Sulcide 28f. Locetion (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

he ettending physicien end ned for use as the burial-tran Records, P.O. Box 68760 page 2 certificete hes Division of Vital Tessie this ctor:

Physician

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Director

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items 23a

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Physician

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Medical Certification: To

4 Homicide

29a. Certifier

Baltimore, Maryland 21215-0020

Director

Funeral

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16 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
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29b. Signature end title of certifie

29d. Date signed (Month, Dey, Year) 198

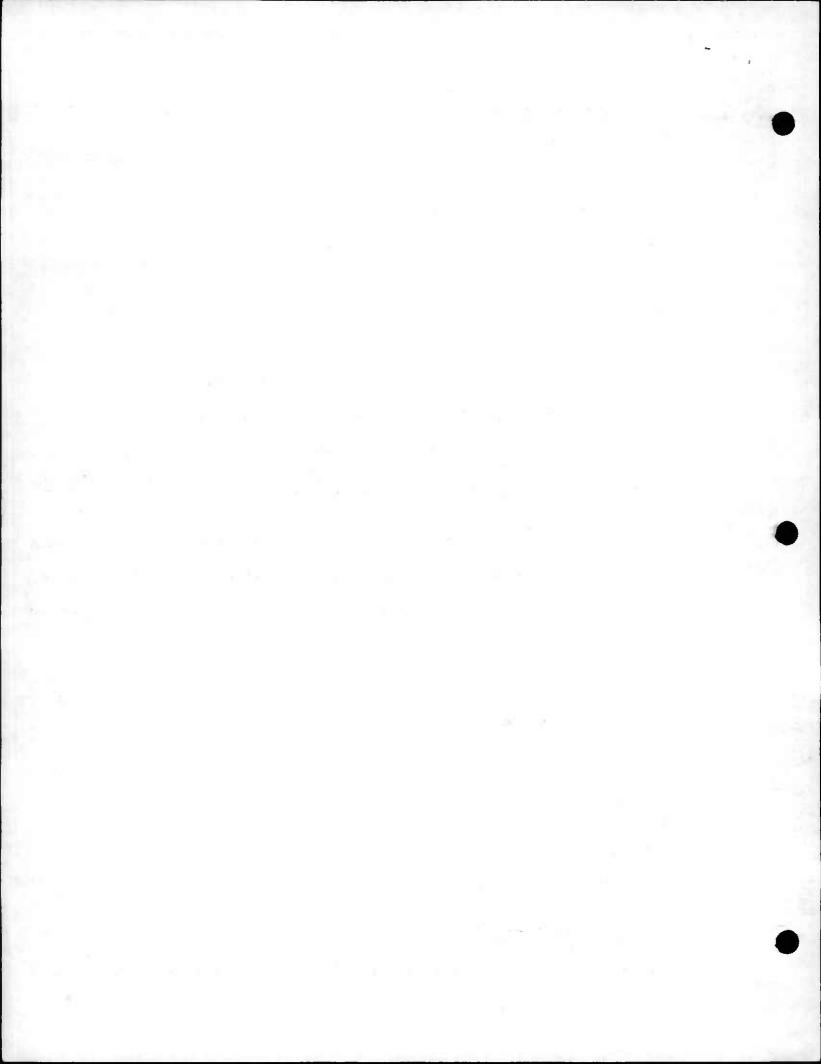
30. Name end add s of perso who completed cause of deeth (Item 23e) (Type, Print) alde MI) St. Agnes

Mospital

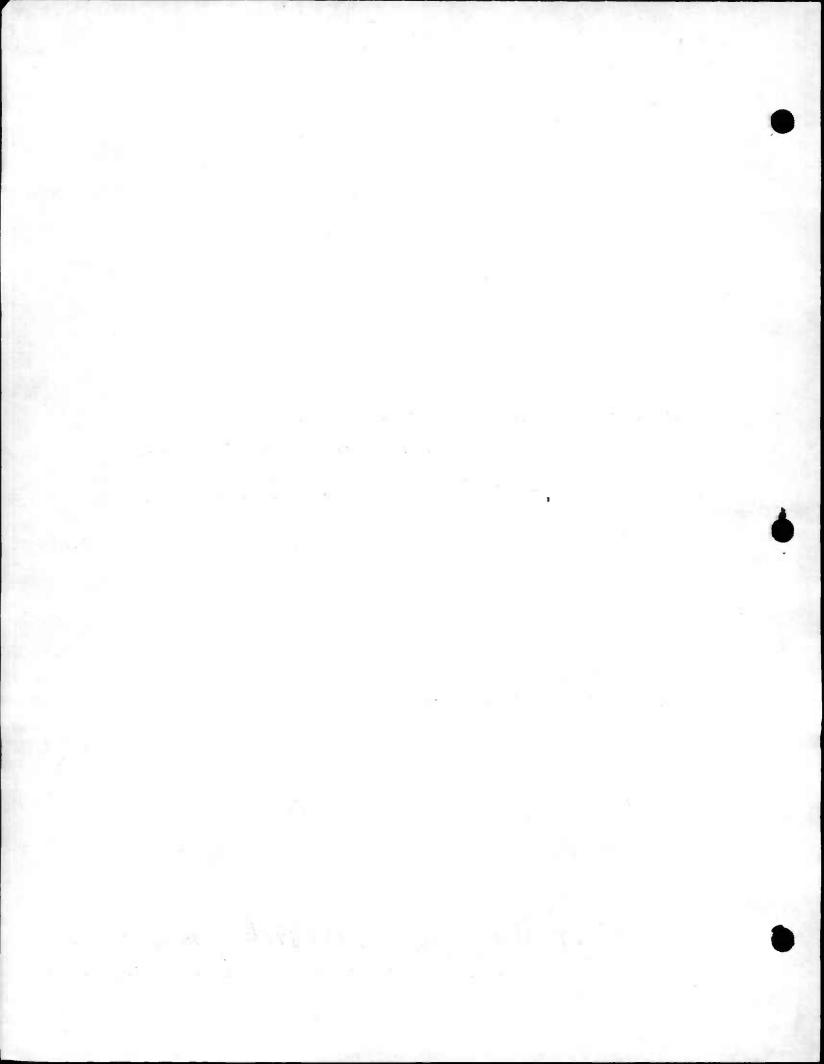
Baltomore, Marylandi

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signature



		Certificate of Deat	46	g. No. 98 23444
п	Physician	Decedent's Name (First, Middle, Last)	2. Date of Deal Month	Dev Year
	/Medical	Alma May Blitz		1, 1998 Year 6:10 p.m.
	Examiner		Town, or Location of Death.ure1	4c. County of Deeth Prince George
	Funeral Director		der 24 Hrs. 8. Date of Birth	
	pu k	Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits
	f sho	MD Howard Laurel		1 ☐ Yes 2 No
	The Protect	10e. Street and Number 10f. Zip Code	1	Og. Citizen of What Country?
	N with	8450 Leishear Road 20723		USA
Maryland 21215-0020	2 should be filed within 72 hours after death with the Maryland and Mental hygiane. is marked other than "natural", or items 23s or 28s-f show raumatic event, the Wedical Exeminar must be notified at To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic If Yes, Specify Cuban, Mexical If Yes, Speci		14. Race - American Indian, Black, White, etc. Specify: White
5-0	natur natur	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during m	nost of working	16b. Kind of Business/Industry
121	ed within 72 hor ygjane. or than "netura rt, m. tedien!	Elementary/Secondary (0-12) College (1-4or 5+) title, DO NOT use retired)		
7	77 75 1	12 Ø Co-Owner 17. Father's Name (First, Middle, Last) 18. Mo	other's Name (First, Middle, I	Auto Supply
an	id be fi ental H ked out ic ever o Be		ne Bartholow	nation Surrently
Z	Maryland d 2 should be filed the and Mental Hyge the marked othe traumatic event,	19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Num		r. City or Town. Stata. Zip Coda)
- P= 5.2	and 2 seeith ar n 27 ia	William E. Blitz/Husband 8450 Leishear Road		
Baltimore,	77.58	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or Town, State
E		1 Burial 2 O'Cremation 3 Removal from State 4 Donation 5 Come (Spanish) Baltimore Washington	Cr. 8/3	Laurel, Maryland
alti	permit. Pege Department of important: If any injury or pace.	21. Signature of Funeral Service Moensey 22. Name and Address of Fer		
0	Ped Ping	Fleck Funeral	I Home, Inc.	numal Manual 20707
4		7601 Sandy S 23a. Parts Enter the disense, or complications that caused the death. Do not enter the mode of dying, such	as cardiac or respiratory arr	est, Approximate
	Physician			Onset and Death
	/Medical Examiner	Immediate Cause Final Acata Care brownscarlas	Accident	Merites
	A CONTRACTOR OF THE PARTY OF TH	resulting in death) Due to (or as a consequence of):		
	executed in and ial-transit	b		
	rificate be executed og physicien and as the burial-transit Aedical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Due to (or as a consequence of):		
68760,		Cause. Enter Underlying Cause (Disease or injury that initiated events		
89	g phy as the	resulting in death) Last Due to (or as a consequence of):		
Box	attendin for use	d		
	death ce	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pe	ert I. 23b. Did to	bacco use contribute to the cause of death?
P.0	res that the death certificate be igned by the attending physicial to detached for use as the but iby Physician/Medical	Weter totic Carcinoma		es 2 No 3 Probably 4 Unknown
Ś	bed by	World Total		,
Vital Record	The lew requires that also has been signed be page 2 should be determined.		24a. Was a perform	med? available prior to
ec	has by ge 2 st	PART AND THE SECOND PROPERTY OF THE SECOND PR		completion of cause of death?
H	Com		1 🗆 Y	es 20 No 1 Tes 20 No
N N	Physician: The risis certificate and director, page Co	examiner?	lace of Death (Check only or	
o	hya high	1 Tas 2000 1 Inpatient 2 ER/Outpatient 3 DOA 4/2	Nursing Home 5 Raside	ence 6 Other (Specify) ow injury occurred
	After funer funer	1 PNatural 5 Pending (Month, Day Year) Injury Work?		w injury occurred
vision	of or Attending P 3 after death. a-Director: After t ad in by the funer Certification:	3 Suicide 6 Could not be		treet and Number or Rurel Route Number,
ă	or of the	4 ☐ Hornicide building, etc. (Specify)	City or Town	1, Stele)
	Me Hospital on 24 hours att he Funerat Di pletely filled in edical Cer	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, data (Check only one)	and place, and due to the codeath occurred at the time, d	ausa(s) and mannar as stated. ata and place, end dua to the cause(s)
- News	Withing Comp	29b. Signeture and title of certifier 29c. License number	er 2	19d. Date signed (Month, Dey, Year)
5		William Wavenin 1/3	3916 1	Jugart 3, 1998
)/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0/	of the non-
	State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	or had	Last 10102
	Registrar	ALLG 3 1998 Hule Davidson Randale		

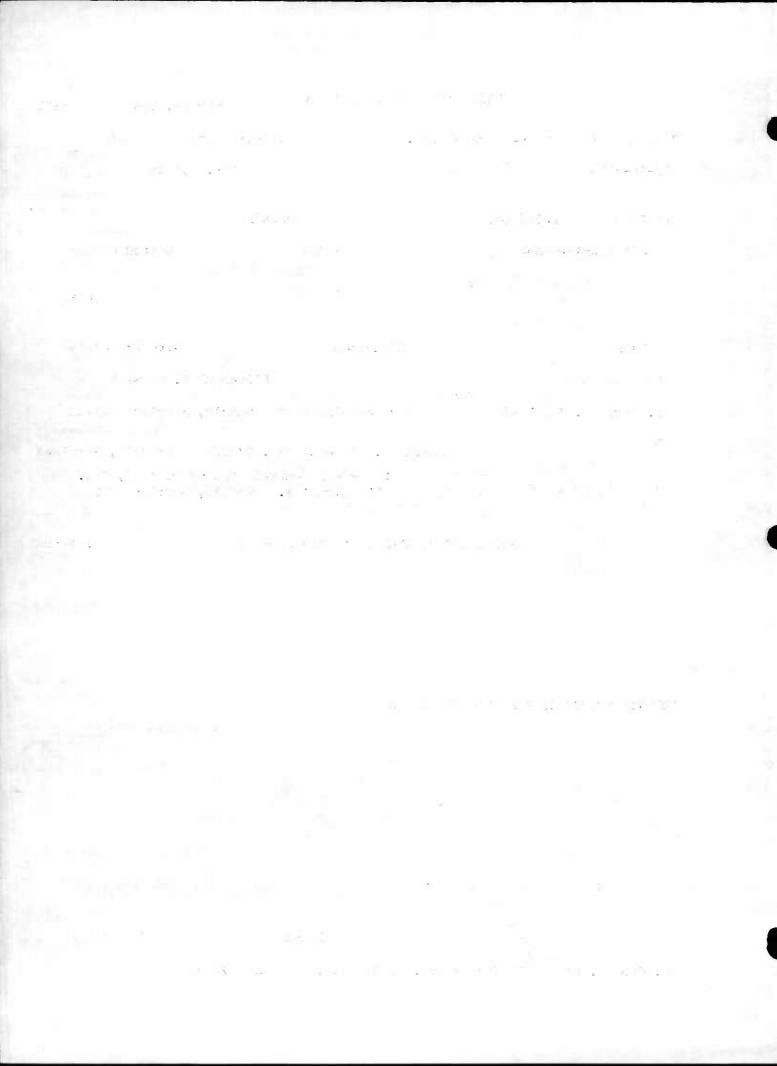


State of Maryland / Department of Health and Mental Hygiene 0 9

				Certificate	of Death		Reg. No.	० ८०५५			
Physician			abeth An	na Blacho	wicz	2. Date of De Month	Day 26, 199	Year 8 4:10			
/Medical Examiner	An English Mama /If and Institution	rive street end number	r)		4b. City, Town,	or Location of Deet					
Examine	Johns Hopkins Ba	yview Medi	cal Ctr.			more Cit		N/A			
Funeral Director	212-30-4176	Sex 7. A 1 M 2	ge (In yrs. lest birt	hday) If Under 1 Y Yrs. Months D		Ain. (Month, D	orth ey, Year) 9,1934	9. Birthplece (State or For Country) Maryland			
ehow ed at	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Lir 1 ☐ Yes 20			
vith the Mer or 28a-f	Maryland B 10e. Street end Number	altimore		10f. Zip Co	Dunda	LK	10g. Citizen of V	What Country?			
th with 23a or 121 be relative to 101 le		Road			1222			d States			
natural; or items 23s or 28s-f show scient Examiner must be notified at search by Europeal Director	3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?] No	13. Wes Decedent It Yes, specify 1 ☐ Yes 2 ☑	of Hispanic Origina Cuben, Mexicen, Pi No Specify:	? (Specify Yes or Nuerto Rican, etc.)		e - Americen Indien, ck, White, etc. White			
natural',	15. Decedent's		16e.	Decedent's Usual O	ccupation	unding	16b. Kind of Bu	usiness/Industry			
within she.	(Specify only highest (Specify only highest (Specify only highest (O-12) 8 Years	College (1-4o		life. DO NOT use r	etired)	WOIKING	Auto Processir				
EI to E		st)		9200112119	18. Mother's	Name (First, Middle					
V # D 9	Frederick Lang				E	Clizabeth	A. Stew	art			
thand 2 should be file thealth and Mental Hy tem 27 is marked other other traumatic event	19e. Informent's Name/Reletionship Mr. Lewis S. Bl						rai Route Number, City or Town, Stete, Zip Code) undalk, Maryland 21222				
2 To 100	20a. Method of Disposition		e cemeter	Disposition (Neme y, cremetory or othe	r piece)	Date		City or Town, State 1k, Maryland			
permit. Page Department of Important: If any injury or phice.	21. Signature of Editoral Service Cochee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, I 7922 Wise Ave. Dundalk, Maryland 2										
	23a. Part T. Enter the disease, or co shock, or heart failure. List or	mplicetions thet cause ly one cause on each	ed the death. Do r line.					d 21.222 Approximete Interval Betweer Onset end Deat			
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE CARDIOVASCULAR DISEASE 9. Due to (or as e consequence of):										
be de la la la la la la la la la la la la la		b	Due to (or as e t	consequence or).	344						
licate be executed physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause, (Disease or Injury c.										
- O U	thet initiated events resulting in death) Last Due to (or es a consequence ot):										
ath co		u						1			
d by the etached		wishing.			se given In Pert t.		23b. Did tobacco usa contributa to the cause of deal 1Ã☐ Yes 2☐ No 3☐ Probably 4☐ Unknown				
been sign should be							s en eutopsy formed?	24b. Were eutopsy tindir available prior to completion ot cause ot death?			
sician: The law require certificete has been si irector, page 2 should in						1□	Yes ZNo	1 Yes 2 No			
ysician: The secrificate director, pag					28. Place of	Death (Check only	one)				
S S D	1 ☐ Yes 2 No	Hospital: 1 Inpat	tient 🏖 ER/Ou	tpatient 3 DOA	Other: 4 Nursin	ng Home 5□ Res	sidence 8 Oth	er (Specify)			
Attending Physic death. ector: After this by the funeral diffication: To		28a. Dete of In (Month, D		rime of 28c.	of 28c. Injury at Work? 28d. Describe how Injury occurred						
offal or Attending Pours after death. Final Director: After the filled in by the funeral Certification.	3 Suicide 6 Could no determine	(Street and Numbown, Stete)	ber or Rural Route Number,								
n 24 hours after or ne Fundral Direction of State of Stat		Physician: To the bes aminer: On the basis and manner	of examinetion and					anner es steted. end due to the ceuse(s)			
2	29b. Signeture and title of certifier	29d. Date signe	ed (Month, Dey, Year)								
		April			н35593		71	30/48			
	30. Name and address of person wt Dr. John J. Loh			(Type, Print) Baltimor	e, Maryla	and 2122	1				
	31 Date tiled (Month Day Year)	32 Regis	trar's Signature								

Registrar

AUG 3 1998 Julia Davidson-Randelle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth July 30, 1998 **Physician** Alice Lura Booth 4:20 am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner 12875 Highland Road Highland Howard County If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 7, 1915 if Under 1 Year Birthplece (State or Foreign Country) Ohlo 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 10 M 200 579-32-7018 83 Yrs. **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be notlined. 1 ☐ Yes 2 ☐ No Maryland Howard County Highland Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12875 Highland Road 20777 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: g white 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) french teacher education 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Henry Bartlett Van Hoesen Ruth Sara Hutchinson 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ms. Sally Booth-Schwadron/daughter 3657 Phesant Drive, Ann Arbor, MI 48013 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2000 Removel from Stete Metro Crematory 31 JULY 98 Baltimore, MD 5 Other (Specify) 4 Donetion Signeture of Funeral Service Licenses 22. Name and Address of Fecility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical nmediete Ceuse (Final ourin 1 EARS diseese or condition resulting in death) Examiner Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy page 2 1 Yes 2 No 1 Yes No certificate Division of Vital 25. Wes case referred to medical examiner? 8 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ä 27. Menper of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: Atter 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide Hospital or 124 hunaral P Describing Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es stated. Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a, Certifier Medical (Check or one) To the Within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a MI 31, D 356

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70832

Registrar

State

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

1998

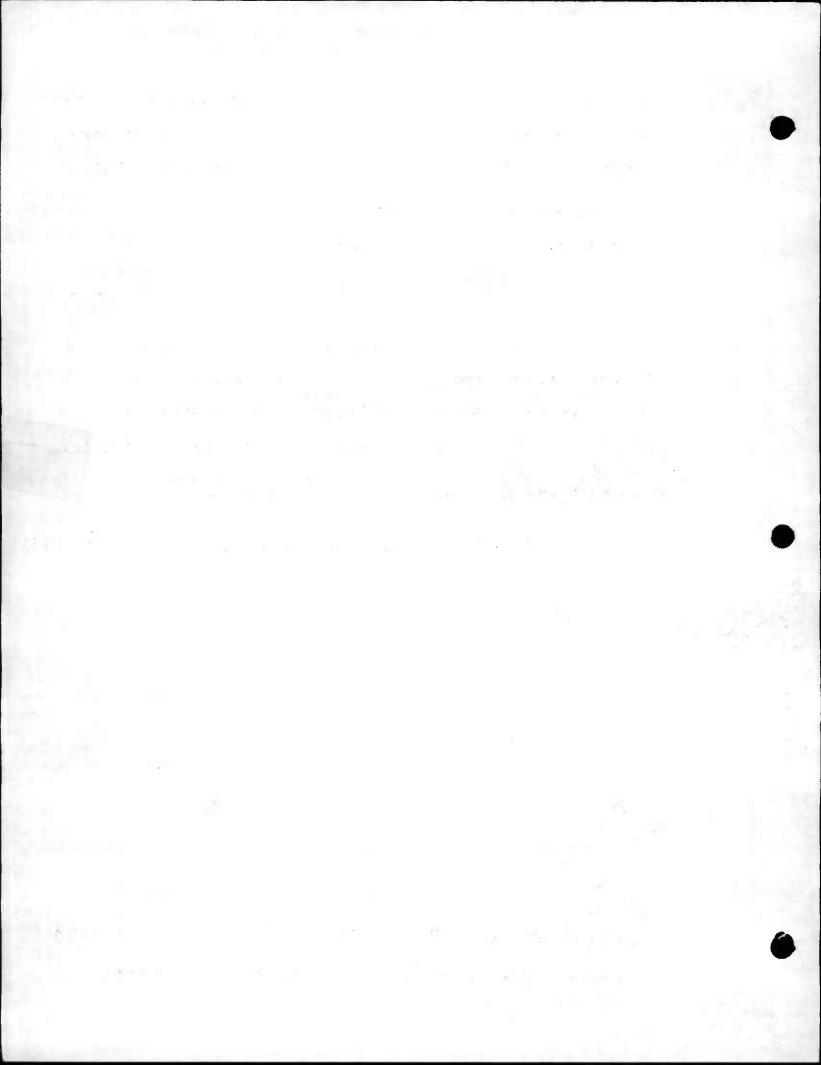
32. Registrer's Signeture

Lika Davidson-Randall

Karım

AUG

31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23447 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yvonne Florine Burns 8:30 am July 30 1998 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death 9213 Crownwood Road Ellicott City Howard County If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 200 Yrs 188-20-7906 71 September 25, 1926 Pennsylvania Usual Rasidanca of Dacedent 10c. City, Town or Location 10d. Insida City Limits 1 Yas XXNo Howard County Maryland Ellicott City 10g. Citizan of Whet Country? 10e. Street and Number 10f. Zip Code 9213 Crownwood Road 21042 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas ﷺNo If Yes, Give Yaar or Dates: 1 Navar Married 2 Married 1 ☐ Yas ANNo Specify: White Specify: 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade complated) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Health Care Medical Secretary 12 18. Mother's Nama (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Donald Edwin Wertz Irene C. Ebright 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Joseph Burns - Son 9213 Crownwood Road, Ellicott City, Maryland 21042 20b. Place of Disposition (Nama of cematary, crematory or othar place) Disposition 20c. Location - Clly or Town, Stata 2 Cremetion XXRemovel from State Altoona Grandview Cemetery August 3, 1998 tion 5 Other (Specify) Pennsylvania Signature of Funaral Servica Licensee 22. Nama and Addrass of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 ant. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one ceuse on each lina. Approximata Interval Batwaan Onset end Death Immediata Cause (Final disease or condition resulting in daath) Due to (or es e consequence of) months Bradi Sequentially list conditions, if any, leeding to immediata cause. Enter Undarlying Causa (Disaasa or Injury that Initiated evants Dua to (or as a consequence d) lation Dua to (or as a consequance of): rasulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Ses 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24e. Was an eutopsy performed? complation of cause of death? 1 Yas 2 46 26. Placa of Death (Check only ona)

cal Physician/Med þ Completed Be 2

Certification:

edicai

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental thygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinal mate to indicate at

permit. Pages Department of Important: If it any injury or o

Physician

/Medical Examiner

Dia.

1Se

Division of Vital Records, P.O. Box 68780

The law requires that the death carri

or Attending Physician:

daath. Director: A

24 hours

within 2

has

cartificate

After this funeral

Baltimore, Maryland 21215-0020

25. Was case referred to medical examinar? 1 Yas 2 No 27. Manpar of Death 5 Panding invastigation 2 Accident 6 Could not be 3 ☐ Suicida

4 ☐ Homicida

29a, Cartifian

one)

Hospital: 28a. Date of Injury (Month, Dey Year)

28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify)

1 | Inpatiant 2 | ER/Outpatiant 3 | DOA 28b. Tima of

28c. Injury af Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Homa 5 Assidance 6 □Other (Specify)

28d. Dascribe how injury occurred 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end mennar es stated.

Medical Examiner: On the basis of examination and/or truestination in my opinion Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

Olumbia.

29b. Signatura and titla of cartifia

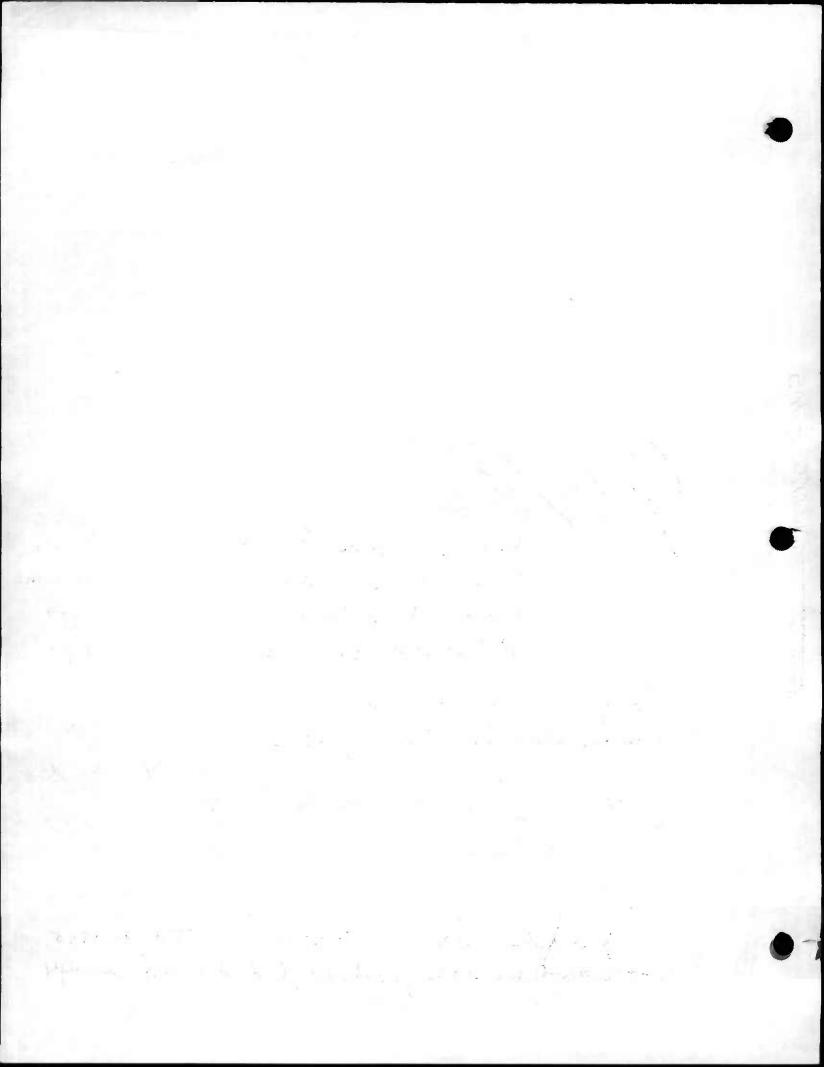
29c. Licansa number 3221 29d. Data signad (Month, Day, Year)

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print)

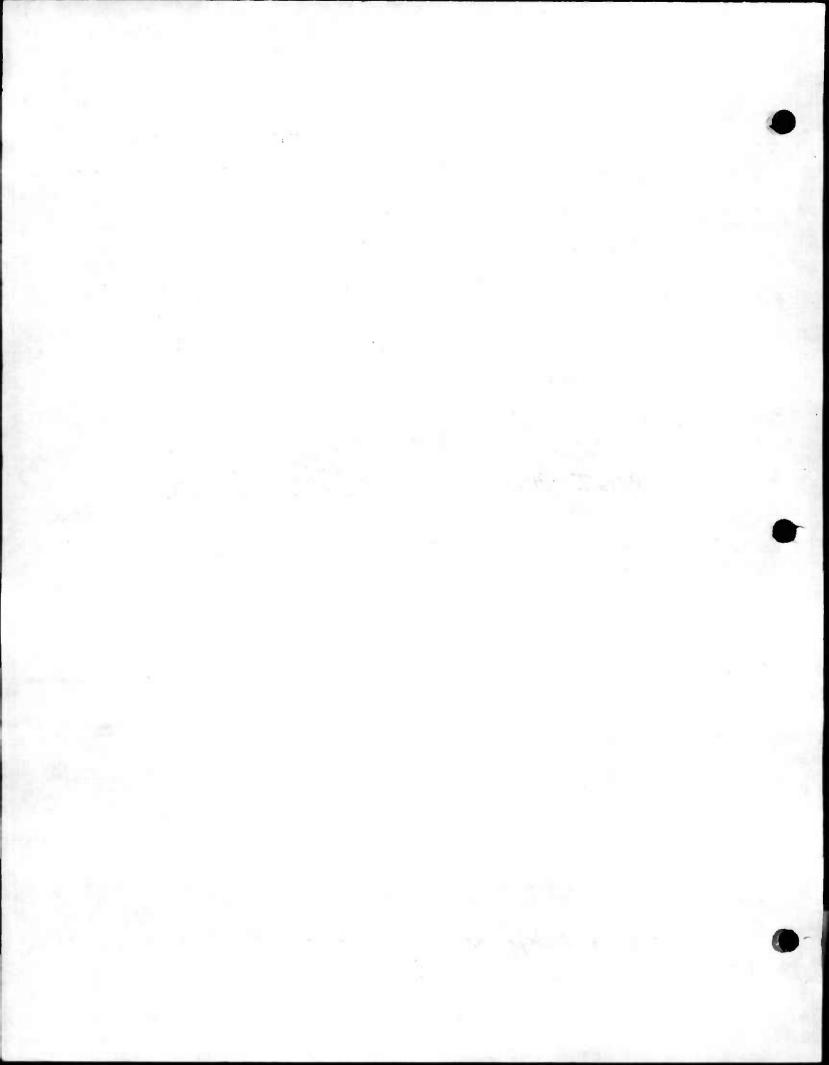
32. Assistration Signature Fundale

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Registrar

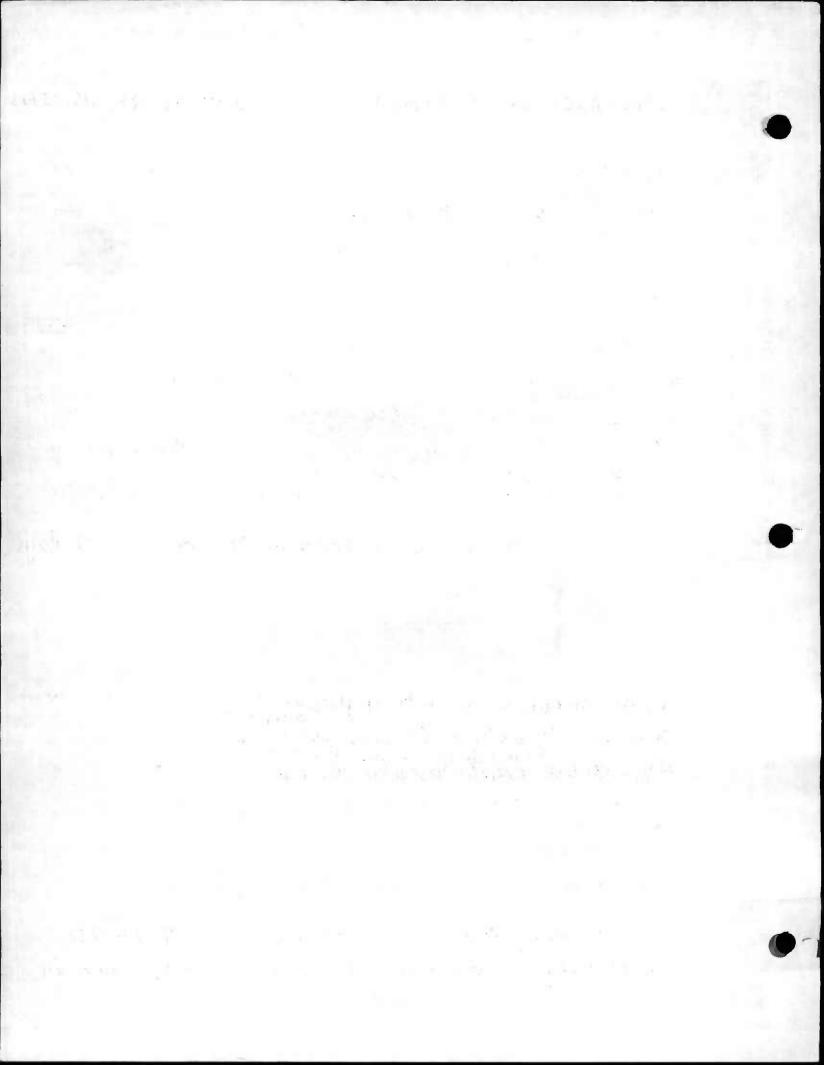


		State of Maryla		tificate of			Reg. No. 9 8	23448	- th		
Physician	Decedent's Name (First, Middle, Last Gertrude Henn	Black				Month	Day	Year			
/Medical	4s Facility Name (If not institution, give				4h City Town or	July Location of Death		998 8:23 A	AM		
Examiner	Broadmead	Street and numbery			Cockeysv						
Funeral	5. Social Security Number 6. Se	x 7. Age (in yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	s. 8. Date of Bir		Birthplace (State or For Country)	oreign		
Funeral Director	219-20-7032 15 Usual Residence of Decedent	New Jersey									
Maryland of show filed at	10a. Stata 10b. County Maryland Baltimor		ckeysvi					10d. Inside City L 1 ☐ Yes 2			
her death with the Maryland heme 23e or 25e-f show fret must be notified at Furneral Director	10e. Street and Number 13801 York Road		31 7	10f. Zip Code 21030			10g. Citizan of W				
_ 2 2 2 7	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub		Specify Yes or No rto Rican, etc.)		- American Indian, ; White, atc. White			
Maryland 21215-0020 42 should be filed within 72 hours at th and Merical Hygiene. 7 le marked other than "natural", or traumatic event, the Medical Exam To Be Completed by 8	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Decec (Give life. I	lent's Usual Occu kind of work done DO NOT use retire	pation during most of wo d)	orking	16b. Kind of Business/Industry				
d 21 filed will they the mit, the		4	Home	maker			Own Ho				
DE SERVE BE	17. Father's Name (First, Middle, Last)					ame (First, Middle,					
arylan should be nd Mental narked comments ev uments ev	John H. Henr				Gertruc	ie	Piero	e			
Tan day	19a. Informant's Name/Relationship (T)					Rural Route Numb					
	Marilyn B. Nuttle			Bellona				land 21212			
Baltimore, Me semit. Pages 1 and 2: Separament of Health as mportant: if Item 27:1s my Injury or other trea.	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	remover from State		sition (Name of natory or other pla int Crema		8/1/98		City or Town, State re, Marylan	d		
Ball pemit Depart import any inj	21. Signature of Funeral Service License Service T. The Service Licens	itte	22 M	Name and Address 1 tchell-	wiedefel	d Home, Baltimore	Inc.	212			
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de- ne cause on each line.						Approximate Interval Betwee Onset and Dea	en ath		
/Medical Examiner	Immediata Cause (Final disease or condition resulting in death)	METASTATIC Due to	BREAST					2 YEARS	;		
swouted n and isl-transit Examiner	Sequentially list conditions,	b	(or es a conseq	uence of):							
And Market	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
P.O. BOX at the death can tby the attende etached for use	Part It. Other significant conditions co		sulting in the u	nderlying cause gi	ven in Part I.	23b. Dld	tobacco use con	tribute to the cause of d	death?		
						10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M U				
Poord requir						24a. Was	24a. Was en autopsy parformed? 24b. Were autopsy fin available prior to completion of cau of death?				
The law sta has page 2						10	Yes 2 No	1 Yes 2 No	5		
VITAL The sicient The conflicate rector, page Co	25. Was case referred to medicat	100			26. Place of De	eath (Check only	ona)				
Or VITA Physician: this certific ral director,	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA O	hon	Home 5 ☐ Resi		r (Specify)			
	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	Wo			how injury occurre				
DIVISION C but or Attanding P as after death. al Director: Aftert ed in by the tuner Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, ferm, str ify)	eet, fectory, office	HE	28f. Location (City or To	Street and Numbe wn, Stata)	er or Rural Route Number	r,		
DIVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification		sician: To the best of my kr ner: On the basis of examin and manner stated.									
Withir Pomp	29b. Signature and title of cedifier	4		29c. Licen		1771	29d. Date signed	(Month, Day, Year)			
) () udh () An	doll mo		1305	46498	2	July 30,	1998			
10	30. Name and eddress of person who o	ompleted cause of death (Ite	om 23a) (Type		La		oury 50,	1770			
12	Judy Davidoff, M.I	3346 Pape	r Mill		oenix, M	D 21131		241			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign		N7.							



State of Maryland / Department of Health and Mental Hygiene Items: 16b,19a per F.H. G-762 8/3/98 reb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 16:05 HRS **Physician** 29, MARGARET COTTMAN /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Battimore Decours 1105 pital If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yaar 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 10 M 200 F -17-20-829 Yrs. Director Usual Residence of Deceden 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2□No NA Director Ma Daltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 3926 21213 U. SA edardale Koad Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 Yes 2 No Specity: Black Specify: þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grede completed) ELECTRIC Western College (1-4or 5+) Elementary/Secondary (0-12) Zyears 12th grade abores 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Naurence Collun 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Aptol Varte Balto, Md Warren A COM LENORA Avenue 20b. Place of Disposition (Neme of semetery, cremetory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State Arbuhs 4 □ Donation 5 □ Other (Specify) Memorial 3-98 Name and Address of Facility 21. Signature of Fusteral Service Licens 300 Ba 140, Md 21215 Wabash Herenue 23e. Part1. Enler the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** cerebellar strokes /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, attanding physician for use as the buria Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Staphylococcal bactere þ bacteremia 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy endstale reval disease page 2 Hyperdeusive 25. Was base referred to medical 1 Yas 2 No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital Hospital of Attending Physician; 24 hours aftar death.
Funeral Director: After this certifice Be director 26. Place of Death (Check only one) examiner? Hospital: 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2€ No funeral 28c. Injury et Work? 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D complately filled i 1 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number analle Raul D18362 -UD 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) Komal K. Dang M.D. Suite 308. Balto. Md 21229 3455, Wilkens Ave 31. Date filed (Month, Day, Yeer) 330 Registrate Signatur State 1998 Registrar



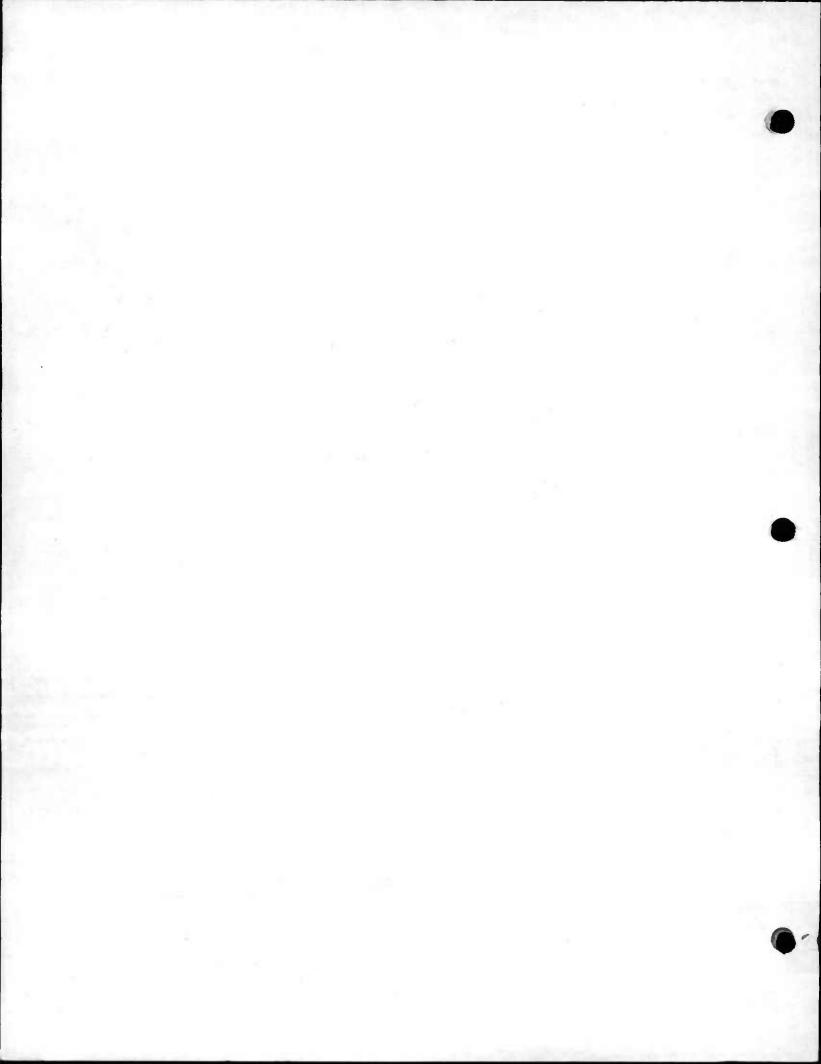
State of Maryland / Department of Health and Mental Hygiene 23450 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 3. Time of Death Day Physician INEZ PRYOR DUER 4b. City, Town, or Location of Death 29, 1998 ath 4c. County of Deeth 10:45 AM /Medical 4e Fecility Neme (If not institution, give street end number) Examiner GLEN MEADOWS MEDICAL CENTER Glen Arm Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs A-239-26-9672 Director Jan 2, 1919 North Carolina Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore County 1 ☐ Yes 2 No Glen Arm Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5 finer man be permit. Peges 1 and 2 should be filed within 72 hours attar death v
Department of Health end Meniel Hygiene.
Important: If itam 27 is marked other than "natural", or flema 23a and injury or other traumatic avent, the Medical Examinations. 11630 Glen Arm Road 21057 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dales: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 21215-0020 1 Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Key Punch Operator Railroad Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Robert M. Pryor Ferrie Underwood 19e. Informeni's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Marybell Blakesiee 8742 Stockwell Road, Baltimore, Maryland 21234 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Malhod of Disposition 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 8/1/98 Timonium, Maryland 21. Signature of Funeral Service Licensea

Martin D. Lawson 22. Name and Address of Fecility Mitchell-Wiedefeld Home, Inc. Plantin D. Lawson (M00358) 6500 York Road Baltimore Maryland 21212

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Maryland 21212

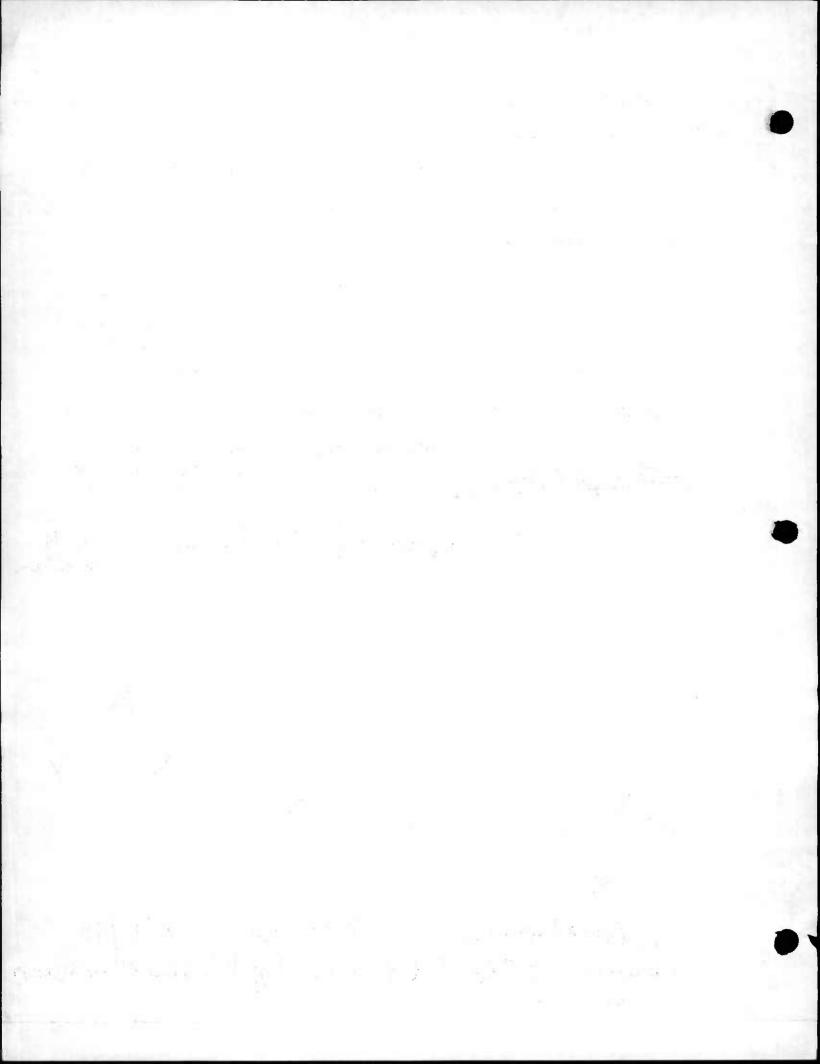
Approximate shock, or heart feiture. List only one cause on each line. Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that intieled avents resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760, Due to (or as a consequence of) The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? mellitus 1 Yes 2 No 3 Probably 4 Unknown diabetes signed b Records, þ 24b. Ware eutopsy findings evailable prior to completion of cause of death? page 2 should Completed 24a. Wes en eutopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificata Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending To the Hospital or Attanding within 24 hours stier death.
To the Funeral Director: Afty completely filled in by the fun investigetion 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and manner steted. 29a. Certifler (Check only 29b. Signeture and was certified 29c. License number 29d. Dale signad (Month, Day, Year) TU(430,1998 D 29705 nu 30. Name end eddress of person who completed cap deeth (Item 230 (Type, Print) Charles Street, Towson, Maryland 21204 Anthony Riley N. 32 Registrar's Signature 31. Dele filed (Month, Dey, Year) State 1998 AUG Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

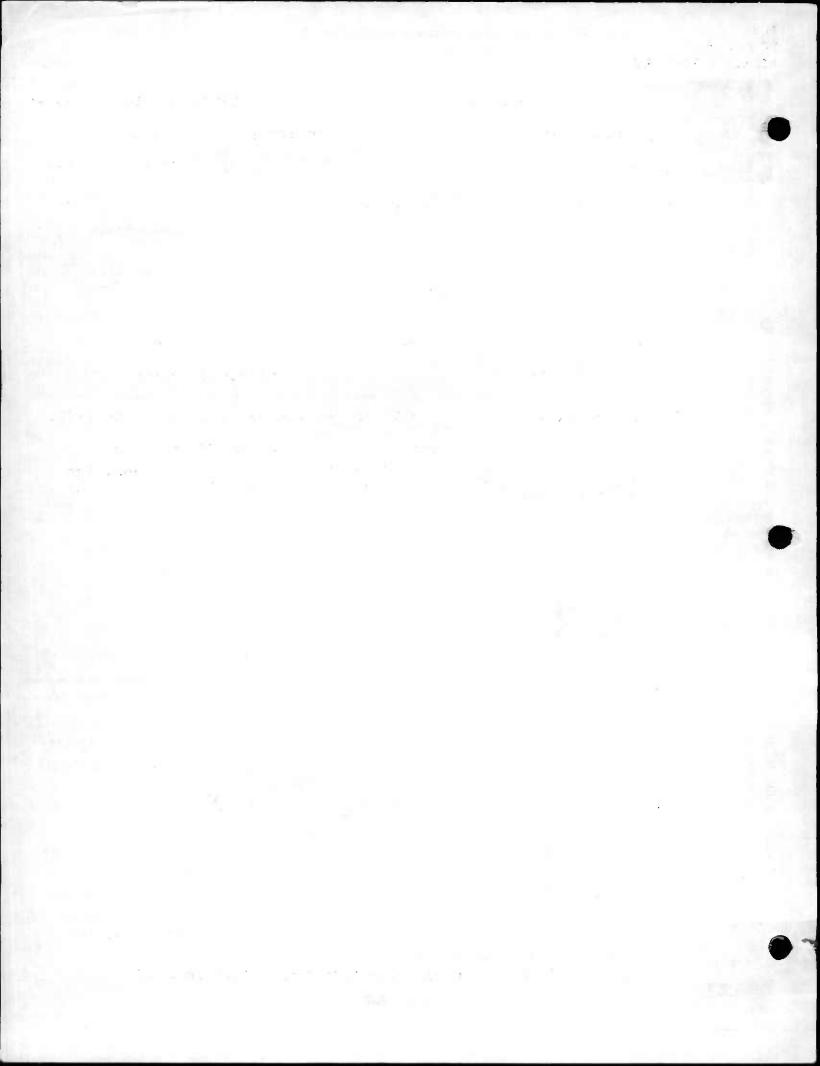
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Euparal		5. Sociel Security Number	-		Age (In yrs. las	st birthday)	If Under 1		r 24 Hrs.				
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MO N			County		10c. City,	Town or Lo	cation					1	0d. Inside City LI
28a-f st	ctor	MD	BALT	IMORE				CATONS	/ILLE				1 ☐ Yes 2X
3a or 28	al Director	10e. Street and Number 7 G RAMBLI	NG OAL	KS WAY			10f. Zip Co	21228	3		10g. Citizen o	What Cour	•
"natural", or items 23a or 28a-f show odical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ≰No			t of Hispanic Or Cuban, Mexica [No Specify		ecify Yes or No- Rican, etc.)	В	aca - Americ lack, White,	etc.
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Hygiene. ther than "r ant, the Mac	Completed	(Specify only highest grade col			College (1-4or 5+)		Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) FOREMAN			ng	PHARMACEUTICAI WAREHOUSE		
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Health e em 27 is other trau		PATRICIA L		(WIFE)				NG OAKS					
5 = 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crer 4 ☐ Donation 5 ☐ C	nation 3		cen	netery, crem	sition (Name natory or othe OGE MEM	of r place) IORIAL I	PARK	Dete	20c. Location	- City or To	own, State
Department important: I any injury o		21. Signature of Funeral S	THE RESERVE OF THE RE			22	. Name and A	ddress of Facil	ity WIT	ZKE FUN	ERAL H	OMES,	INC.
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32 Honistrar's Signature Randall

State Registrar 31. Date filed (Month, Day, Year)

1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 28 1998 7:35PM July Kathleen Smith Hart Frey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street end number) **Examiner** N/A 113 Croydon Rd. Baltimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F Yrs 73 Director 212-22-4385 31,1925 Balto.MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at 1 XYas 2 □ No Director MD. Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 113 Croydon Road 21212 death v Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or iten any injury or other traumetic event, the Medical Example. Black, White, etc. 1 ☐ Yas 2]X No If Yes, Give Yeer or Detes: 1 Never Married 2 XMarried 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Education Secretary 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middle, Last) Be Sylvester Clarence Smith Irene Elizabeth McNulty 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, Stete, Zip Code) Baltimore, MD 21212 Dr.Donald T.Frey Husband 113 Croydon Road 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Mathod of Disposition Wurial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/1/98 Towson, Maryland Maria Mt. Sanature of Funeral Service Lice 22. Name and Address of Facility Mitchell-Wiedefeld Home, 5500 York Road, Balto.MD 21212 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one cause on each line. Approximete Interval Batwaen Onsat and Daath Physician Carcinima Jovan 19 mos /Medical Immediate Cause (Final disease or condition rasulting in death) **Examiner** Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that Initiated events resulting in death) Lest Pue Due to (or as e consequenca of): P.O. Box 68760 Physician/Medical Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? Brenchopheumonia signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ been sig 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? Completed 24a. Was an autopsy parformed? cata has 1 Yes 2 No 1 □ Yes 2 □ No this certificata Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director, Be 25. Wes case referred to medical 26. Placa of Death (Chack only one) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 5 Panding Investigation 1 Natural Injury 1 Yes 2 No 2 Accident filled in by the 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical 29c. Licensa number 29g Date signed (Month, Dey, Year) 29b. Signature and title of certifier eth (Itam 23a) (Type, Print) 5 GOOD SAMARITAN HOS PIT miD. 32. Segistra estionature 31. Date filed (Month, Day, Year) State 1998 3 AUG Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth Month ALLEN GREEN Aug 1998 15256 IST 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death CHURCH HOME & HOSPITAL BALTIMORE N/AMonths Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign (Month, Dey, Year) DEC. 20, 1946 WASHINGTON, DC 5. Social Security Number 7. Age (In yrs. last birthdey) 1 MM 2□ F Months Yrs. 216 50 0258 Usuel Rasidence of Dacadent 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. BALTIMORE REISTERSTOWN 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citlzan of Whet Country? 40 BOND AVENUE arital Status 12. Was Decadent Ever in U,S. Amed Forces? 1 Yes 2 No If Yes, Giva Yeer or Dates: U.S. OF A. 21136 13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - Americen tndian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) N/A LABORER TRANSPORTATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) ALLEN GREEN, JR. CARRIE LEE FRIERSON 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zlp Code) ERIKA GREEN 2512 DRUID PARK DRIVE (DAUGHTER) BALTO., MD. 21215 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town BALTO . Date 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 8/3/98 CATONSVILLE, MD. Co. 21. Signeture of Forneral Service License T. ²²LEWIS 16 GWYNN FUNERAL HOME **GWYNN** 21215-6393 4517 PARK HEIGHTS AVE. 23e. Part 1. Entar the disease, or complications that baused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause of a each line. Approximete Intarvel Batween Onset end Deeth tmmediata Ceusa (Finel diseese or condition resulting In death) . HEPATIC FAILURE WEEKS Due to (or es e consequence of): ALCOHOLIC HEPATITIS WEEKS Sequantially list conditions, if eny, leading to immediate ceusa. Enter Underlying Cause (Disaasa or Injury Due to (or es e consequence of): thet initiated evants rasulting in daeth) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? resparaton hepatorena 1 ☐ Yes 2 No 25. Wes case raferred to medical examiner? Wowl 26. Place of Deeth (Check only one)

Physician /Medical Examiner Physician/Medical Examiner

ŏ Department Department Important: II any injury o

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

10a. Stete

Funeral

Director

The law requires that the death certificate

or Attending Physician: this After t s efter death.
I Director: After of in by the fun

ò

Completed

Medical Certification: To Be

Division of Vital Records, P.O. Box 68760.

Hospital

4

within 24 hours of To the Funeral DI completely filled In

State

31. Dete filed (Month, Dey, Year) AUG Registrar

29b. Signature and title of certifier

1 Yes 2 No

5 Pending Investigation

6 Could not be determined

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicida

> MD, FCCP

29c. License number

28c. tnjury et Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and dua to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner stated. 29d. Dete signed (Month, Day, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

036845

1 ☐ Yes 2 ☐ No

3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how Injury occurred

Aug, 1st, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) & A1- CH | NGUYEN MD FCCP PATUXENT PKWY, # 200, COLUMBIA, 10724 LITTLE MD 21044

32. Registrer's Signeture Alia Savidan Trochasa

↑ Inpatient 2 ER/Outpat

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

10,

. .

State of Maryland / Department of Health and Mental Hygiene 23455 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 98 July 29, 10:59am Gibson Christine /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) **Examiner** Baltimore 441 East 27th Street If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 65 Yes. Director 225-40-9679 12-19-32 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County ul Hyglene. other than "natural", or items 23s or 28e-f show vent, the Medical Examiner must be notified at 15 Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 East 27th Street Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Narried 1 Yes 2 No Specify: Black Maryland 21215-0020 If Yes, Give Year or Dates: t ☐ Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) South Baltimore Elementary/Secondary (0-12) College (1-4or 5+) General Hospital Nurse Technician 8th Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnema) d 2 should be fill h and Mental H I is merked oth Be 2 Gordon Canada Emma Carey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Hern 27 is n any Injury or other traun 211 East North Avenue 2nd. Fl. Balto, MD. Gibson altimore, 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 08+03-98 Warsaw, VA. 1. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Part Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth Physician rlusalean Immediate Ceuse (Finat disease or condition resulting in deeth) yocardial Infarction Examiner Due to (or es e consequença of) tupestension Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury be to (or es e consequenca of): YISARS Tupe 2 Diabetes
pas to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events resulting in death) Lest 23b. Did tobecco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown B signed to þ 24b. Were eutopsy findings evellable prior to completion of causa of deeth? 24a. Was en eutopsy Completed performed? page 2 1 Yes 2 No 1 Tyas 2 No certificate director, 25. Was case referred to medical 26. Plece of Deeth (Check only one) Be Other: 4 ☐ Nursing Home 5 🌠 Residence 6 ☐ Othar (Specify) 1 Yes 2 No 10 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Menner of Deeth 1 Denturel 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: Affar 5 Pending investigation Injun Attending I or Attending after death. Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, State) à 4 Homicide 24 hours a Funeral D 1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and mannar steted. To the T 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) issie Lemun 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Leonard K. Kassis, MD Union Mem. Hospital 201 University Pkwy

32. Régistrer's Signature Pandalle

DHMH 16 Rev 6/95

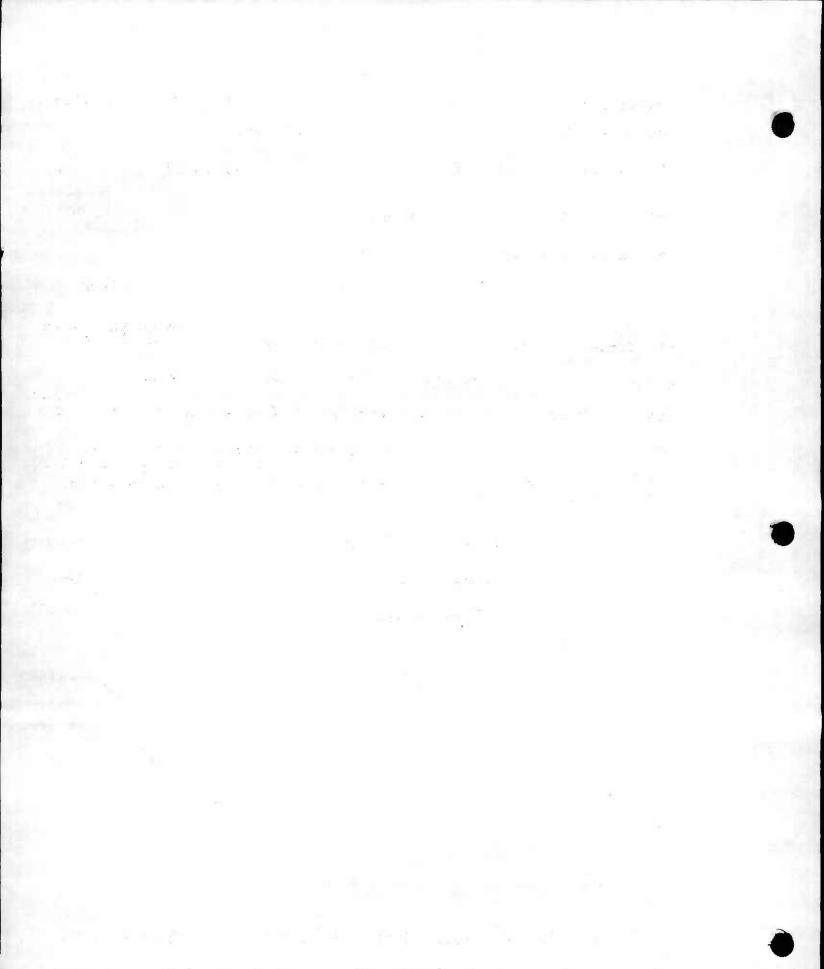
State

Registrar

31. Dete filed (Month, Day, Yeer)

AUG

3 1998

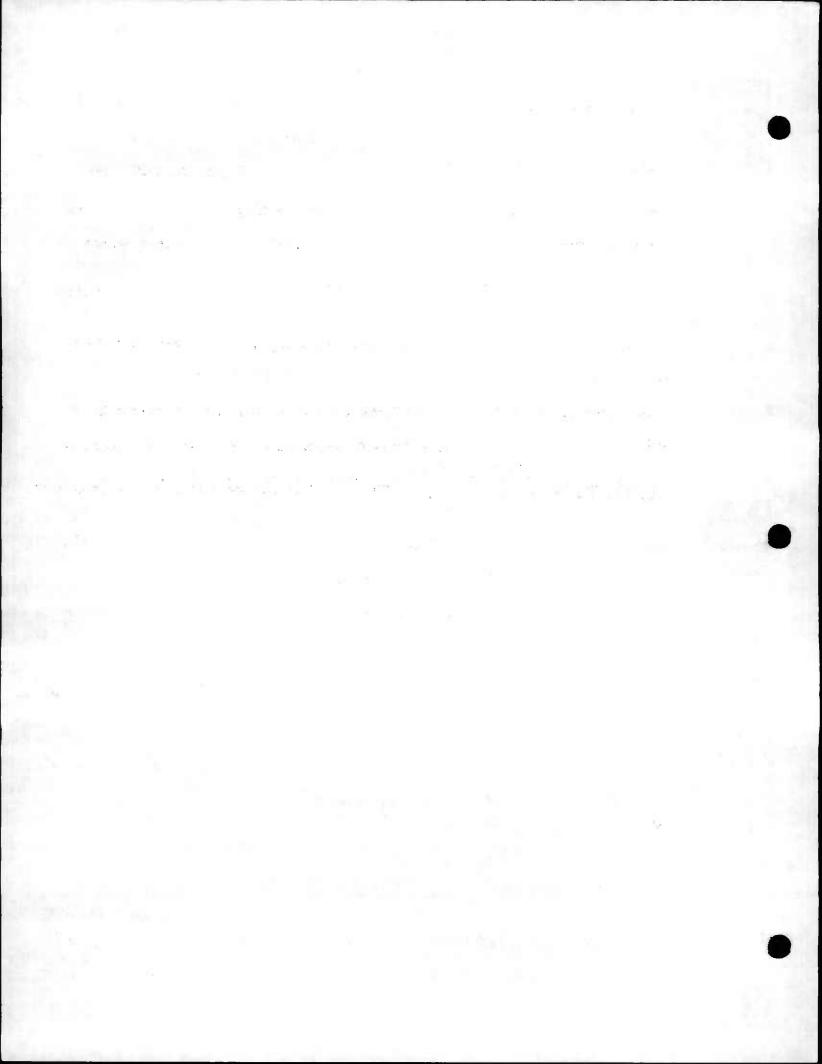


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1:55pm August atherine Green /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) **Examiner** Baltimore City Sinal Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Birthplece (State of Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys 1 M XX F 77 Yrs. 215-03-6077 Director August 30,1920 MD Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Haalth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any filury or other traumatic event, in Modical Examinating the nutritied at an once. 10e. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits Yes 2□ No N/A Baltimore City Md Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21230 United States 1467 Towson Street Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 Never Married Married 1 ☐ Yes XX No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 XXX Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 8th N/A Assembly Line Worker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be James Rolka Janina Lipka 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Constantine J. Green / Husband 1467 Towson Street, Baltimore Maryland 21230 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slete Burial 2 Cremetion 3 Removel from Stete Holy Cross Cemetery August 4, 1998 Baltimore MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical 9 years Liver Failure Examiner Due to (or es e consequence of): Physician/Medical Examiner -Iver metastases ettending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Breast Cancer Division of Vital Records, P.O. Box 68760 The law requires thet the death certificate be Due to (or es e consequence of): n signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? is certificate has been si director, paga 2 should Completed 2 X No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica staly filled in by the funeral director, p. Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 10 2 ER/Outpetient 3 DOA 28b. Time of 27. Manner of Death Dete of injury (Month, Dey Year) 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, streel, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier jouhn, Pho, DO AS 2402321-59-9169 August 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Shelley A. Quarless Sinai Hospital 2401W Belvedere Ave Baltimore, MD 21215 31. Dete filed (Month, Dey, Year) 32. Register's Signature

Fulia Davidson Fandsle State 1998 AUG Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month Year **Physician** 9:48 pm Vester Grays 1998 27 Juli /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** University of Maryland Medical System Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Undar 1 Yeer Months Days 9 Birthplaca (Stata or Foraign 5. Social Sacurity Number **Funeral** 18 M 20 F Mary /and 50 Yrs. 219-50-1103 Director Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Baltimore Directo Maryland 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda permit. Pages 1 and 2 should be filed within 72 hours aftar death with Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examinat must be it once. WSA 21215 3614 ottage Funerai 12. Wes Decedant Ever in U.S. Armad Forces? Was Decedant of Hispenic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - Amarican Indian 11. Marital Stetus Black, White, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married Specify: Black 1 Yes 2 No Specify. Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) unemployed 124 Grad 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Be Gravs atherine. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Ibwn, Stata, Zip Coda) 2/2/5 19a. Informant's Name/Ralationship (Type, Print) Maryland Cottage Battimore Mother 20b. Place of Disposition (Nama of cometery, crematory or other p 20c. Location - City of Town, State 20a. Mathod of Disposition 8/ Baltimore 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Heart Sacred Tesus Cem. 4 ☐ Donation 5 ☐ Othar (Specify) OL 22. Name end Address of Fecility 21. Signatura of Funeral Sarvica Licansas Funeral Tar Maryland 21729 rederick Ave. Baltimore Approximata Interval Batween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Ventricular tachycuidia Examiner Dua to (or as a consequance of): Physician/Medical Examiner Electrolyte abnormalities attanding physician and for use as the burial-trensit The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury Dua to (or as a consequance of): of Vital Records, P.O. Box 68760. Stage renal diseuse that initiated avants rasulting in daath) Last Due to (or es e consequence of) accident Rule cerebrovasialat signed by the a Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown by 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy parformed? Completed After this cartificete has intuneral director, page 2: 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was casa rafarred to madical 26. Placa of Daath (Chack only ona) 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred Certification: Division Attending 5 Panding Invastigation 1 Natural death. 1 Yas 2 No 2 Accidant 6 Could not be datermined 3 Suicide 28a. Place of Injury - At homa, ferm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 2 Hospital of At 24 hours after of Funeral Direct 4 Homicida 24 hours 29a. Certifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Hosp within 24 ho To the Fune completely fi 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified 14 30. Name and address of person who completed cause of deeth (Mam-23a) (Type, Print)

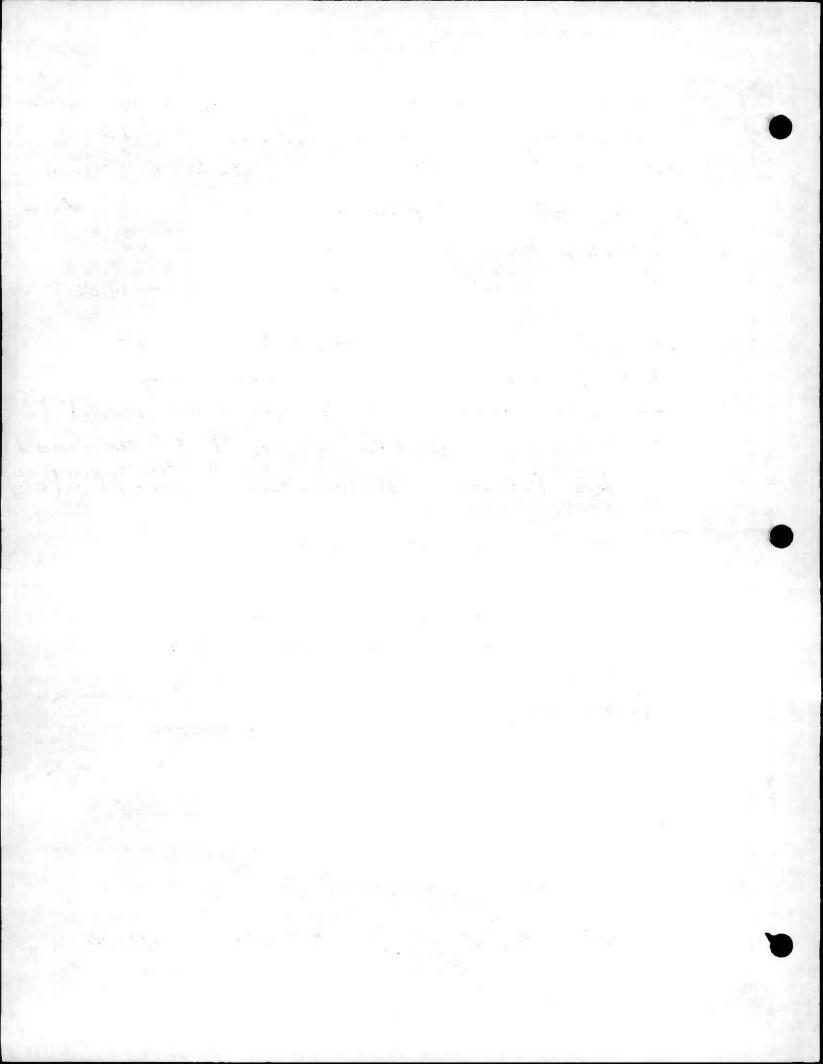
Greene

32. Registrer's Signeture

timora,

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 27 Sall_v TAvloe Groff July 8:20 PM 4a. Fecility Name (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Deeth Brightwood Retirement Community Lutherville Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7, 1924 If Under 1 Months 5. Social Security Number 9. Birthplace (State or Foreign Country) Md. 7. Age (In yrs. last birthday) 1□M 20XE 74 Yrs. 216-20-5894 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10n. Citizen of What Country? 515 Brightfield Rd. 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 [] Ves 2 (ZNo II Yes, Give Year or Dates: 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hollyday Compton Elizabeth Griswold Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Denmead Groff, Jr. P.O. Box 8, Owings Mills, Md. 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 □ Cremation 3 □ Removal from State St. Thomas Cemetery 7/31/98 Owings Mills, Md 4 □ Donation 5 □ Other (Specify) 11824 Reisterstown Rd. 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home Reisterstown, Md. 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio pulmones Immediate Cause (Final disease or condition resulting in death) omin Lover Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use centribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

permit. Pages 1 and 2 should be filled ville begratment of Health and Mental Hygien Important: if item 27 is marked other the any injury or other traumatic event, the pages.

Physician

/Medical

Examiner

10a State

Md.

Funeral

Director

show

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after Hygiane.

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760,

Division of Vital

Funeral

PV

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical p Completed

25. Was case referred to medical examiner? 1 Yes 2 No 27, Manger of Death 1 (Natural

5 Pending investigation 2 El Accident 6 ☐ Could not be determined 3 D Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Yes 2 PNo

29b. Signature end title of ceptifier relonnen MD

W. Univerit

29c. License number

30. Name end eddress of person who completed ceuse of deeth (item 23e) (Type, Print)

William D. McConnell 500

31. Dete filed (Month, Dey, Year) AUG

32. Registrar's Signeture Alia Davidson Bandras

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

State Registrar

DHMH 16 Rev 6/95

0

certificate

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After 1 Attending

6

To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune

Be

To

Certification:

Medical

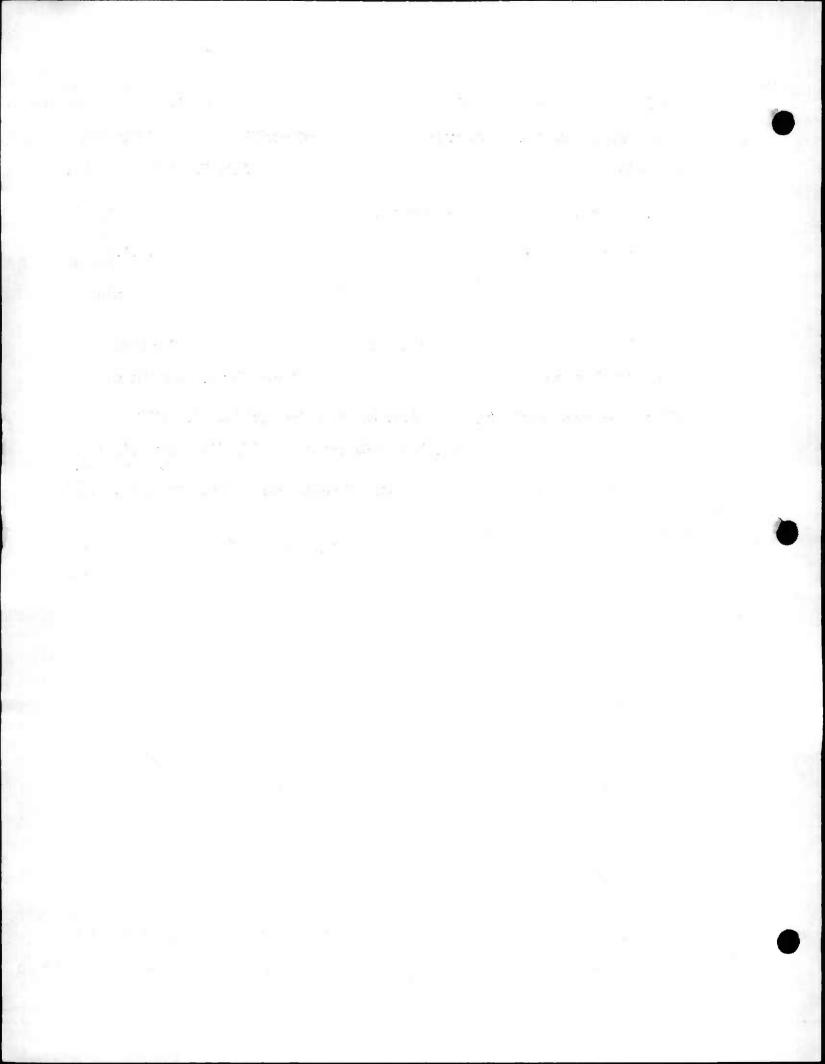
29a, Certifier (Check only 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medicel Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated.

29d. Date signed (Month, Dey, Yeer)

Baltmore 21210

1 ☐ Yes 2 ☐ No



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Mildred E. Gonce **Physician** Month July 31, 1998 11:00AM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 5. Sociel Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Funeral 1 □ M 2X F Months Days Hours Min Yrs. 23/1920 214-01-7038 78 Director Maryland Usuel Rasidance of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28a-f show eny injury or other traumatic event, me Medical France. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD N/A Baltimore Director N☐ Yes 2☐ No 10f. Zip Coda 21206 10e. Street and Numbar 3915 Southern Avenue 10g. Citizan of Whet Country? U.S.A. Funeral 12. Was Dacadant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Raca - Amarican Indian, Black, Whita, etc. 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 Navar Married 2 Married If Yas, Give Year or Datas: 1 ☐ Yas 2 No Spacify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Home Housewife 12. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) John Berger Eva Wolfrum 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Carl J. Gonce 4410 Fieldgreen Road Baltimore, Maryland 21236 20b. Placa of Disposition (Nama of cametery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Holy Redeemer Cemetery 8/4/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funeral Service Licenses 22. Nama and Addrass of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 Approxime death. Do not enter the mode of dying, such es cardiac or raspiratory arrest. **Physician** acute myscarlal infanction
Dua to (or as a consequence of): Immediete Causa (Final disaasa or condition rasulting in death) /Medical **Examiner** Physician/Medical Examiner atherosclerotic Heart Disease Sequentielly list conditions, if any, leading to immadiate causa. Entar Undarlying Ceuse (Disaasa or injury that initiated avants rasulting in daath) Lest Dua to (or es a consequança of): P.O. Box 68760, The law requires that the death certificate be Dua to (or as a consequanca of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Records, 2 24b. Were eutopsy findings eveilebla prior to complation of cause of deeth? page 2 should Be Completed 24a. Was en eutopsy performad? 1 Yas 2 No certificete 1 Yas 2 No Division of Vital or Attending Physicien: director. 25. Was case rafarred to medical 26. Place of Deeth (Chack only ona) Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 24 hours efter death. 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street end Numbar or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) in by 4 Homleida Hospital 1 Certifying Phyaician: To the best of my knowledge, daath occurred et tha tima, data and place, and dua to tha ceuse(s) end mennar es statad. 29a. Certifier Medicai (Check only one) 2 Madical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the ceuse(s) and mennar stated. within 2 29b. Signature and titla of carlifiar 29c. Licanse number 29d. Data signad (Month, Day, Yeer) rulumora, M.D. D13649 PA, M.D. 6012 HARFORD Rd., Baltimore, M. 21219 30. Name end address of person who completed causa of daath (Itam 23a) (Type, Print) CARMONA.

DHMH 16 Rev 6/95

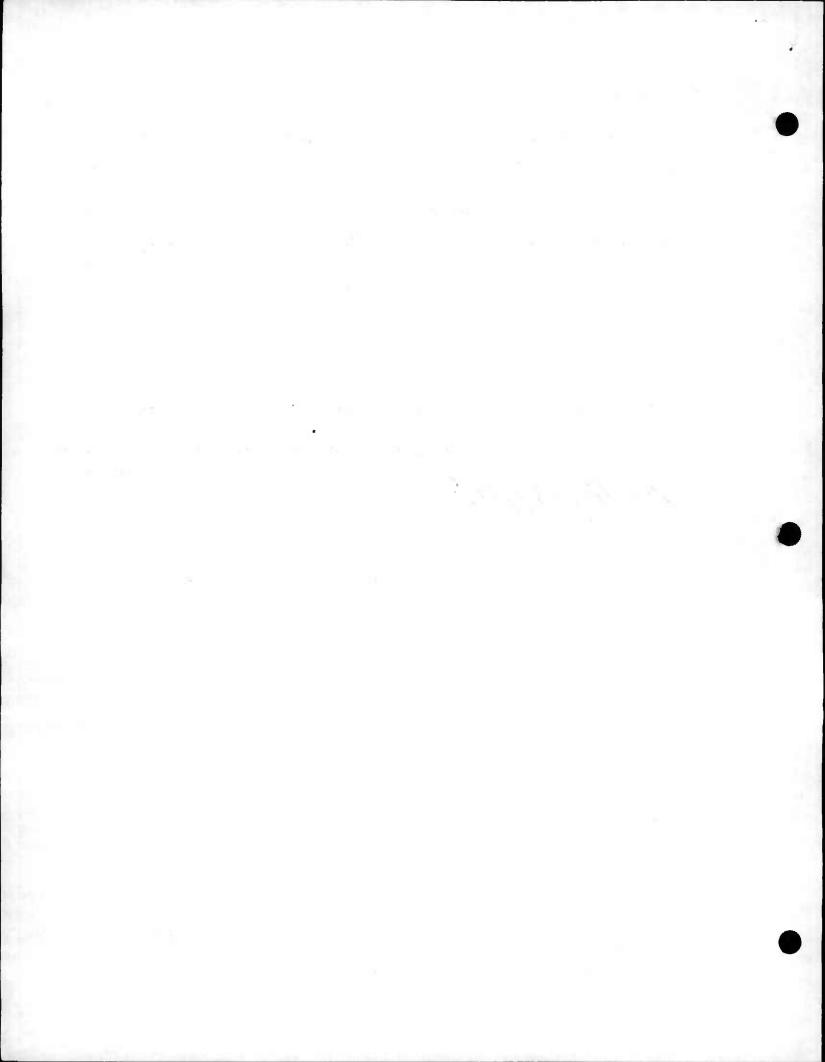
State

Registrar

NESTOR

31. Dete filed (Month, Day, Year)

AUG



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 23460 Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ause 3-22 PM 30 14/4 /Medical 4b. City, Town, or Location of Doubth 4c. County 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Medical Center, 2600 Liberty If Under 24 Hrs. If Under 1 Year 7. Age (in yrs. last birthdey) 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours -44-1851 10 M 20 F 3 Yrs. Director Usual Residence of Decedent 10a. State 10d. inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21215 Funerai Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 943-1□Yes 2☑No Specify. Specify: by BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mentel Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LABORER CONSTRUCTION OTh NA permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If tem 27 is marked oths any Injury or other traumatic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be BELLE LUKE GAUSE GAUSE 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 2801 MARIE W NORFOLK AVE. BALTINORE MD 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriei 2 ☐ Cremation 3 ☐ Removal from State GRRISON 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1102/21 Find Enter the disease, or compile with that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only or couse on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Hypertension 40915 Examiner Due to (or as a consequence of) Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Physician/Medical Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à cete hes been sign, page 2 should b 24b. Were autopsy tindings evellable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 🗆 Yes 20 No certificete Division of Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 10 DOA After this funeral dir 28a. Date of Injury (Month, Day Year) 28c. injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours efter death Puneral Diractor: 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

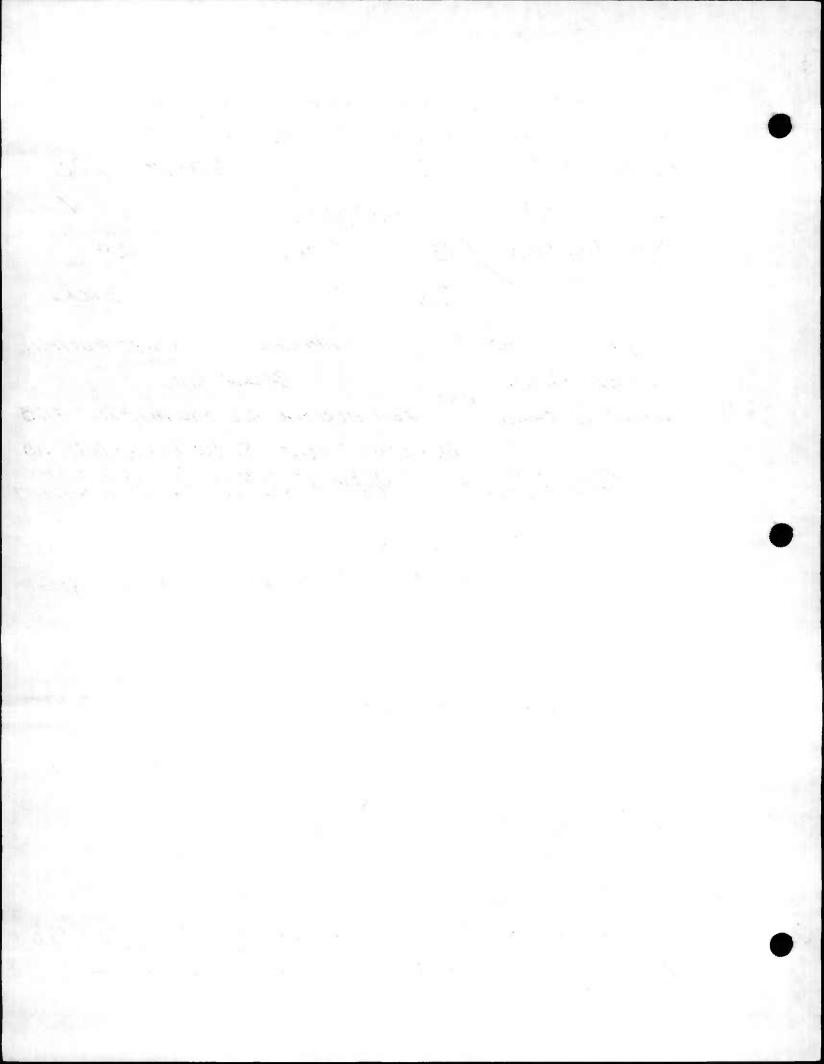
Madical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 2 H Nacom

State Registrar 31. Date tiled (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) AMATUN HAREM 50 (1) COLD

32. Registrar's Signature

Julia Davidson-Randell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Deeth HELWIG ANDREW JULY **Physician** 07 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Neme (If not institution, give street and number) Examiner BON SECOURS HOSPITAL BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JUNE 16, 1910 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Deys Months 1 1 M 2 □ F Director 212-09-8638 88 MARYLAND Usuel Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show rai', or itams 23a or 28a-f show Examiner must be notified at MARYLAND BALTIMORE BALTIMORE 1 ☐ Yes 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1915 VICTORY DRIVE 21227 U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. by 3 Widowed 4 Divorced WHITE 'natural', Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Eiementary/Secondery (0-12) College (1-4nr 5+) 8TH GRADE MACHINE OPERATOR KOPPERS 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health end Mentel Hiant: If item 27 is marked oth Be HERMAN HELWIG REBECCA MARTIN 7 is markac traumatic 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health en Important: if item 27 is any injury or other trau FLORENCE HELWIG (WIFE) 1915 VICTORY DRIVE - BALTIMORE, MARYLAND 21227 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Qther (Specify) 8/3/98 LOUDON PARK CEMETERY BALTIMORE Service Licensee 22. Name end Address of Fecility
HUBBARD FUNERAL HOME INC. 21229 4107 WILKENS AVENUE-BALTIMORE, MD 23e. Pert1. Er er the disease, or complications that caused the didfh. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical NEUMONIA Examiner gestule heart failure
to (or es e consequence of):

gestule heart failure Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest for use as the buriel-tran iension Due to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 2 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred

P.O. Box 68760, The law requires that the death certificate be Records, of Vital Attanding Physician: de de Attan.

Taria de death.

Disector: After h.

E by the funeral dir. Division

21215-0020

3altimore, Maryland

State Registrar

Medical

1 Natural 2 Accident

3 Suicide

29e. Certifie.

4 Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Yes 2 No

tion Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) Aug 1, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

kens AT Ballimor MD 2122

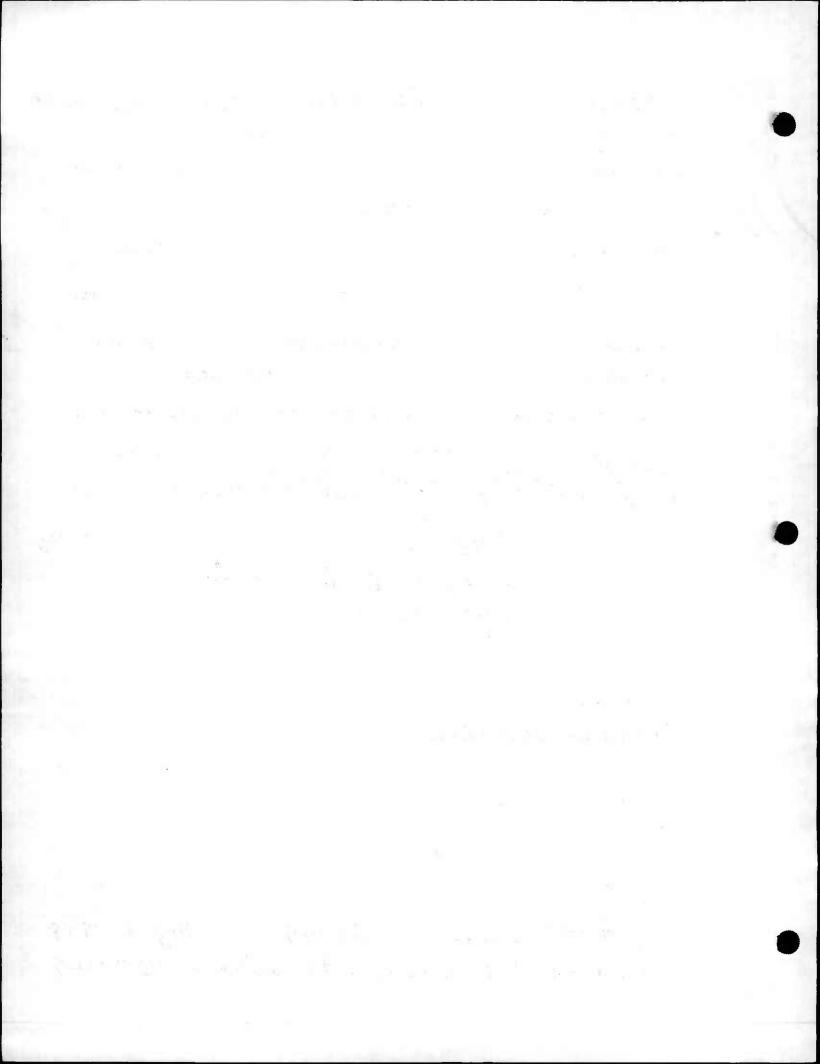
31. Date filed (Month, Day, Year) 3 1998 AUG

5 Pending investigation

6 Could not be determined

ula Davidson Randall

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23462 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death 1145PM **Physician** HA RRIS July /Medical 4b. City, Town, or Location of Death (If not institution, give street end number) 4c. County of Death Examiner Johns Hopkins Geniatri Baltimore Paltimore U.y.

If Under 24 Hrs. 8. Date of Birth
Hours Min. July 17, 1933 Mary Land CS Paltimore City

9. Birthplece (State or Foreign If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days 1□M 2□F XXX 65 Yrs Director 217-22-7543 Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Baltimore City Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 1024 Deck Avenue; Act. 104 21224 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours effer in Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event. It is marked. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown langsharemen docks 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Richard B. Harris Catherine Votlk 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Patricia Harris/ spouse 1024 Deck Avenue; Apt. 104, Baltimore, MD21224 20b. Placa of Disposition (Neme of cemetery, cremetory or other place)
St. Stanislaus Cemetery 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Removal from State
4 Donetion 5 Other (Specify) 29JUL98 Baltimore, MD Mature of Funeral Service Licensee 22. Name end Address of Fecility David J. Weber Funeral Homes David J. Weber Fulletal Indias 401 S. Chester St., Baltimore, MD 21231
Approximate Intervel Between Onset and Deeth att. Enter the disease, or complications that caused the death. Do not enter 23a F **Physician** fmmediate Ceuse (Finel disease or condition resulting in death) DIACHOSED /Medical SQUAMOUS June 1998 cell CARCINOMA OF THE LARYNX **Examiner** Due to (or es e consequence of) Examiner the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury and Due to (or es e consequence of): P.O. Box 68760. ed by the ettending physician detached for use as the bune certificate be Physician/Medical thet initiated events resulting in deeth) Lest Due to (or as a consequence of) 98 Pert fl. Other algniffcent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Pulmonary the pertension Records. by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? peen OBESURV page 2 s hes 1 🗆 Yes certificate DIABBIES 1 ☐ Yes 2 ☐ No mounts Division of Vital Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA After this 28c. Injury et/ Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident Attending 5 Pending investigation efter death. 1 Yes 2 No the 6 Could not be determined 3 Suicide in by t 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 edical 29a, Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner stated. (Check only one) 29b. Signeture end title of confidence 29c. License number 29d. Date signed (Month, Dey, Year) 00052104 July 26, 1998 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY S. 100 5505 BAYVIEW CIRCLE, BAUTIMONE MD 21224 Horkuns

hina Dayason-Randall

32. Registrar's Signature

1998

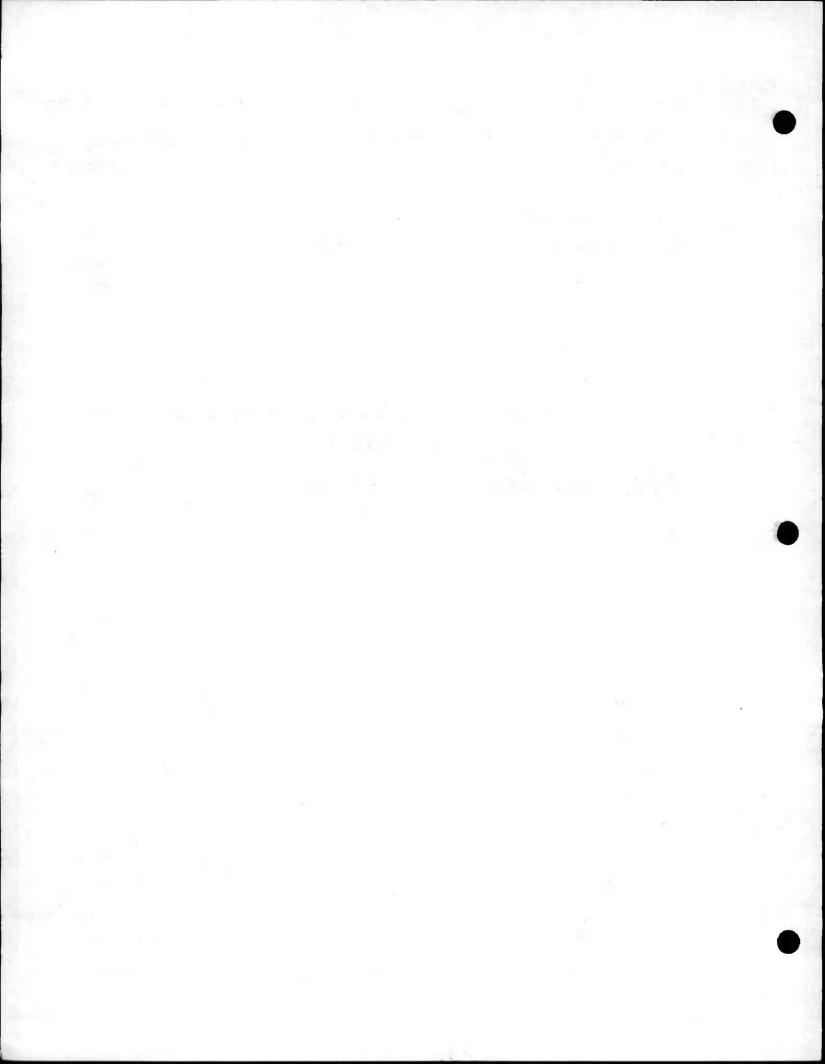
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State

Registrar

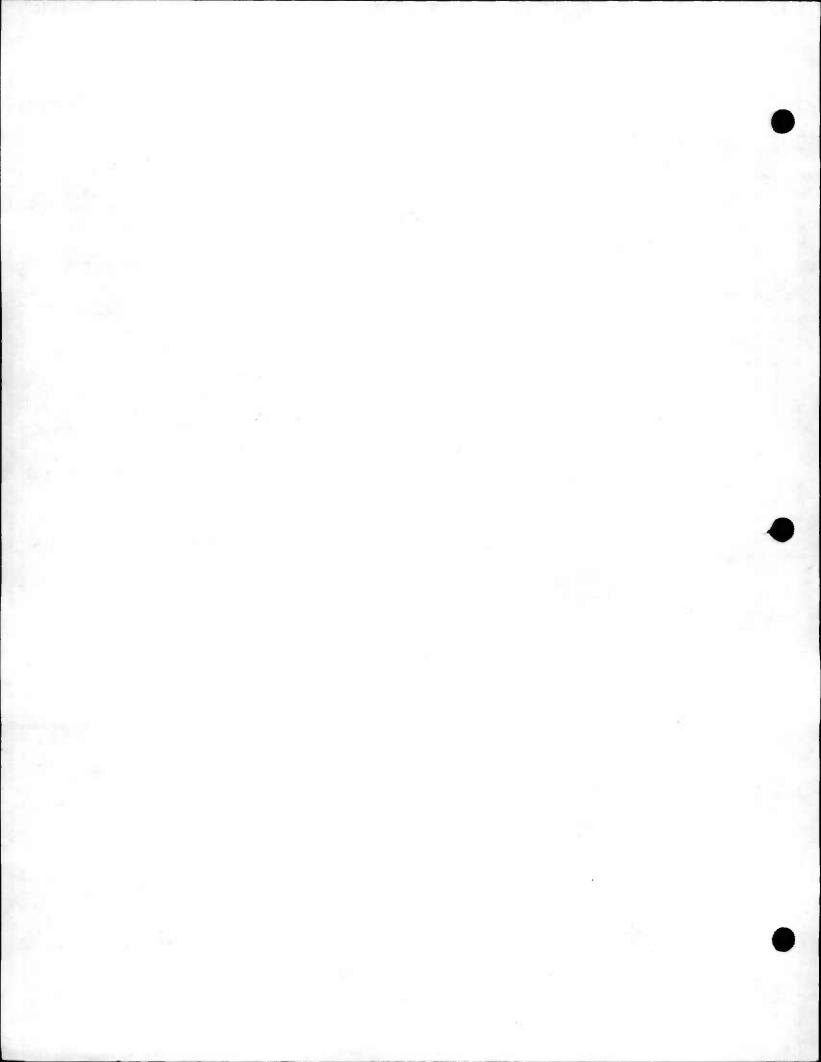
31. Date filed (Month, Dey, Year)

AUG



State of Maryland / Department of Health and Mental Hygiene 23463 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Francis Barry Hennegan 1998 28 12:50 AM July /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home - Ruxton Towson Baltimore | Hunder 1 Yeer | Hunder 24 Hrs. | 8. Date of Birth (Months, Day Year) | Hours | Min. | August 13,1921 6. Sex 1 X M 2 ☐ F 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 219-03-3501 76 Yrs. Director Maryland Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahoe 1 ☐ Yes 2 No Funeral Directo Baltimore Towson Maryland or 28a-1 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 167 Regester Ave. 21212 United States 23a permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Health and Mental Hygienes, important if flow 27 is marked other many injury or other transmission other. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, or Hema 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 M Merried 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 salesman office supplies 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Barry Hennegan Anne Neary 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Hennegan/wife Towson, MD 167 Regester Ave. 20b. Plece of Disposition (Name of cametery, cremetory or other ptace) 20e. Method of Disposition 20c. Location - City or Town, State 1 N Buriel 2 □ Cremetion 3 □ Removel from Stete 4 Donetion 5 DOther (Specify) Dulaney Valley Mem Garden 7/31/98 Timonium, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21. Signeture of Funerel Service Licensee IV Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) Squamous Cell Carcinoma of the Skin /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 alor Attending Physician: The law requires that the death certificate after death.

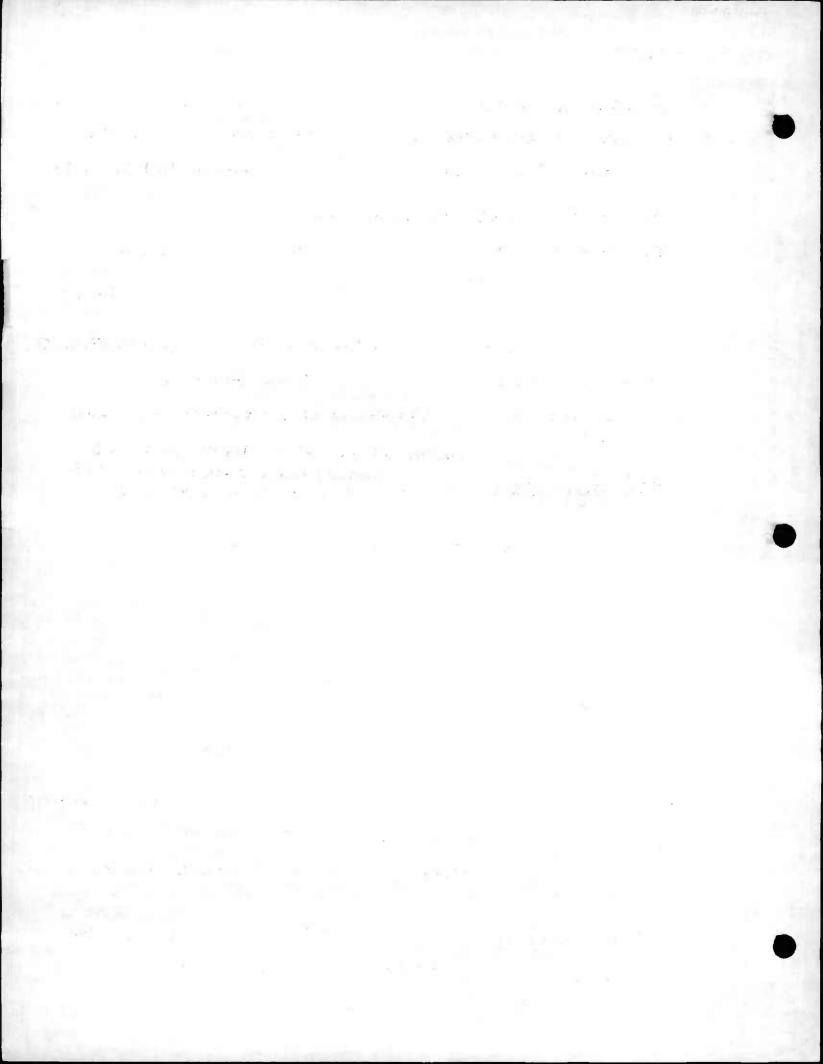
Director: After this certificate has been signed by the attending prival of incy by the funeral director, page 2 should be detached for use as the Due to (or es e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mullitis)ichetes Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. tnjury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 DNaturel 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital c within 24 hours at To the Funeral D completaly filled 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29c. License number 29b. Signeture and file of certifier 29d. Date signed (Month, Day, Year) 3389 28 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 4300 N. Charles St. Robert J. Vissing, M.D. Baltimore, MD 21210 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State AUG chia Davidson 3 1998 Registrar



B.K.S

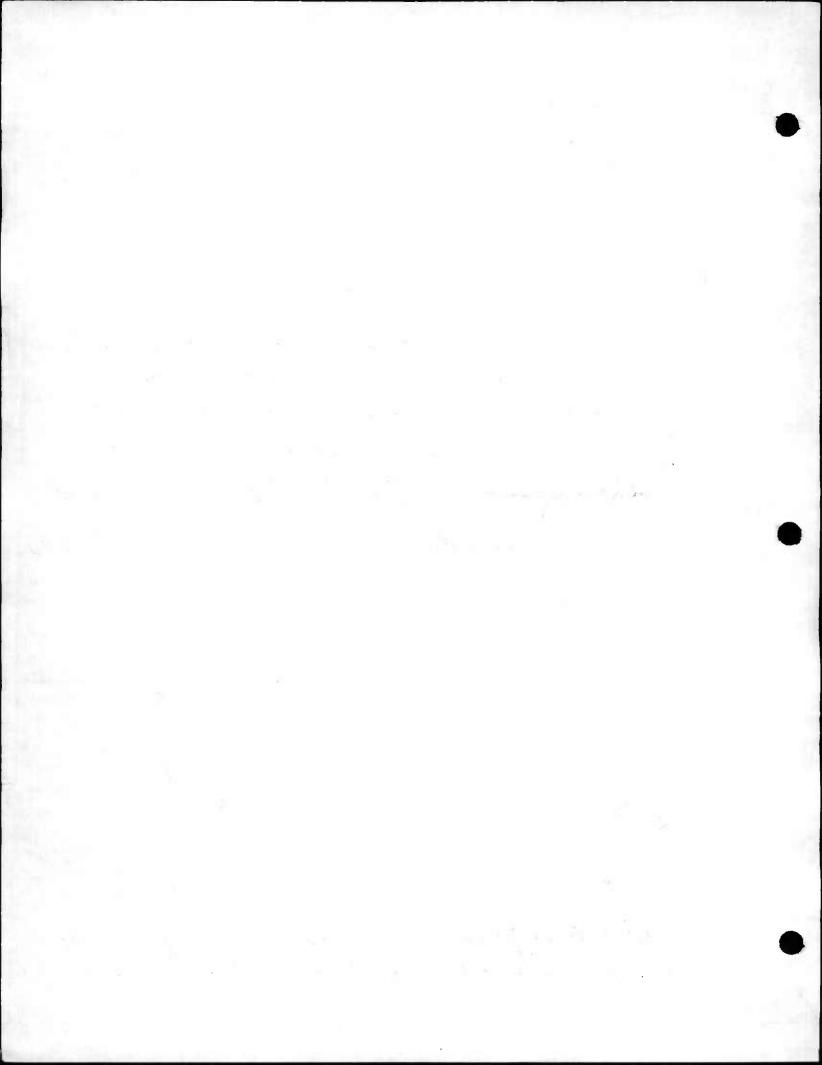
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			Decedent's Name (First, Middle, Last)	1.00				2. Date of De	ath		3. Tima of Death
	Physici		GUSTAV H. H	ORN				JULY	27, 199	Yaar 8	1341 PM
ş.	* /Medic Examin		4a Facility Name (If not institution, give street as	W 100 1			4b. City, Town, or	ocation of Deat			
8	EXUITIO	٠.	PARK & RIDE LOT- ARU	NDEL BEAG	CH ROAD		SEVERNA	PARK	ANNE A	ARUNI	DEL
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday		If Under 24 Hrs. Hours Min.	8. Data of Bir (Month, Da	th v. Year)	9. Birthpi	ace (State or Foreign try)
	Director		215-30-1558 12M 20	81	Yrs.	Working Days	110013	APRIL 1	6,1917	GER	MANY
	P a		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or L	ocation				11	Od. insida City Limits
	sho sho	5									1 □ Yes 2 □ No
	28e-1	Directo	10e. Street and Number	IDEL .	PEARK	NA PAR	K		10g. Citizen of W	That Coun	tor?
	death with the Maryland ma 23a or 28a-f show r must be notified at			d			1146	100	7 2 1111		
	eath m 23	Funerai		Decedent Ever in	U.S. 13.			pecify Yas or No	U.S.	- America	an Indian,
	or iten	F	Arm	ed Forces? Yes 2 No		. Was Decedent of I if Yas, specify Cub	-	o Rican, etc.)	Black	k, White,	
V		by	If Ye	s, Give r or Dates:	7/11	1 ☐ Yes 2 ☐ No	Specify:		Specify.	wi	HITE
2-00	n 72 hours natural',	Completed	15. Decedent's Education	a to all	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	oation	ting	16b. Kind of Bu	siness/Inc	lustry
7	an en	pie	(Specify only highest grade compl Elementary/Secondary (0-12) Coil	ege (1-4or 5+)							2
7	filed wii Hygien other th	Con	19+4	NIA	5	SUPERINT					Tion Co.
and	d oth	Be	17. Father's Name (First, Middle, Last)					71	, Maiden Sumam	e)	
7	should be nd Mental marked c	2	HEINRICH HOR					FELLE			
Na	2 sh end is m		19a. Informant's Name/Relationship (Type, Prin			ling Address (Street		-	-	State, Zip	Code)
9	ges 1 and 2 should be filed to of Health end Mental Hyg If item 27 is marked othe or other traumatic event,		MRS ANNAMARIE H	ORN	39 E	MERSON .	RD. SEV	Date Date	20c. Location -	, Z	1146
0	Peges nant of h ant: If its any or of		1 ☐ Burial 2 ☐ Femation 3 ☐ Removal	from State	cometery, cre	ematory or other pla		-			
Baltimol	t. Pe tant: yury		4 Donation 5 Othar (Specify)	Gr		UNT CRE	MATORY !	7/29/98	BALTO	. M.	0
Da	permit. Pege Department or Important: If i any injury or once.		21. Signature of Funeral Service Licensee		4	22. Name and Addre	ess of Facility MILLER	FUNERA	IL HOME	CH	+1D.
			World Will	ler	h:	527 HARF	FORD RD	BALTO	MD 21	34	
			23a. Part1. Enter the disease, of complications shock, or heart failura. List only one cause	that caused the de on each line.	ath. Do not er	nter the mode of dyi	ng, such as cardia	or respiratory a	rrest,		Approximate interval Between Onset and Daath
F	Physician /Medical		Immediate Course (Final							- 1	Criset and Daam
Q ₂	/wedicai Examiner		immediate Cause (Final disease or condition resulting in death)	MARCT	GUSE	Lor WOL	NO OF H	ODD			
		-		Due to	(ords a conse	equence of):					
	nsit	Examiner	b							i	
-6	be secuted sician and buriel-mansit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	equenca or):				1	
09/00	ficate be a physician ss the burie	edicai	that initiated events	Due to	(or as a conse	ranence of):					
9			resulting in death) Last	Dualo	(or do d corrido	rquoriou ory.					
YOU .	ending use	No.	d								-
	v requiras that tha death certif been signed by the ettending should be deteched for use e	by Physician/M	Part ii. Other algnificant conditions contributing	to death but not re	esulting In the	underlying cause gi	ven in Part i.	23b. Did	tobecco use con	tribute to	the ceuse of death?
	that tha led by th deteche	, h	1 2/11 0/11 1					10	Yee 210 No	3 Prot	pably 4 Unknown
S,	gned be de	þ	LYMPHOMA								
records,	requiras seen sign hould be	2						24a. Was	an autopsy	ava	ere autopsy findings allable prior to
50	2 8 8	Completed						Hos	Olly	of o	mpletion of cause death?
_	The late has page	20							Yes 2□No	18	Yea 2 No
VICAL	sicien: The law scartificate has b director, page 2 s	Be (25. Was case referred to medical				26. Place of De	ath (Check only	one)		
5	Physician: rthis cartific rral director,	2	examiner? XX Yes 2 No Hospital:	1 ☐ Inpatient 2	☐ ER/Outpatia	ant 3LI DOA		fome 5 ☐ Res	denca 6 XXX the	ar (Specify	AT SCENE
	aling Phys h. After this funeral di	 	27. Manner of Death 1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time injury		ry at rk?	1	how injury occurr		7
DIVISION	eath. or: A	Certification:	2 ☐ Accident investigation 7 -	27-97	FOUM 13	391 M 1	Yes 2 No	Susse	-	26.36	
5 ⋅	frer d frect frect in by	E	4 Homicide determined 28e.	Placa of Injury - At building, etc. (Spe	cify)	treet, factory, offica		City or To	1		
2	urs e urs e			K35196					7 1 3		under coun
	Hosp 24 ho Fund Fund Staly (edicai	29a. Certifier (Check only one) 1 Certifying Physician: 1 Medical Examiner: On and	the basis of exami							
	To the Hospital or Attending Physicien: The I within 24 hours efter death. To the Funeral Director: After this cartificate he completaly filled in by the funeral director, page	Mec	29b. Signature and title of cartifier	manner stated.		29c. Licens	sa number		29d. Data signed	(Month	Dav. Year)
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	,6		manine musiky	W	00-> =	D-i-n)			OOH	20, .	
	1)		30. Name and address of person who completed		em 23a) (Type 111 Pe	enn Stree	t, Baltim	ore, Ma	ryland 2	1201	
	Sta	te	MANY DRIFTO A. KON 31. Date filed (Month, Day, Yegl)	SW My. 32. Registra is Sig	matura						
	Registr		AUG 3 1998	Julia	Davidson	Mandell					



	1	1. Decedent's Name (First, Middle, La	ast)	07-20	Certificate o		2. Date of De	Reg. No.		3. Time of Deat
Physicia		Theresa S. It	tze1				Month	3 O	98	11:50
/Medic		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Deat		ty of Death	11.00
Examin	ier	1809 Woodside				-	ore, MI		Ltimo	re
uneral	-			(In yrs. last bir	thday) If Undar 1 Ye				-	
irector .		219-05-7238 Usual Residence of Dacedent	1□M 2□F	79	Months Day	/s Hours Mi	8. Data of Bir (Month, De 2 – 5 – 1	919	Mary	lace (State or Fo try) land
Now H		10a. State 10b. County		10c. City, Tow	n or Location				1	0d. Inside City Li
23e or 28e-f show ust be notified at	tor	Maryland Balt:	imore							1 Yes 2
or 28	Director	10e. Street and Numbar			10f. Zip Code	•		10g. Citizen of	What Coun	ntry?
230		1809 Woodside A	Avenue		2122	7		USA		
al', or items Examiner in	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C		(Specify Yes or No erto Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.
Scal	Completed	15. Decadent's E (Specify only highest gro	ducation	16a.	Decedent's Usual Occ	cupation	orkina	16b. Kind of I	Business/Inc	dustry
than he was	n de	Elementary/Secondary (0-12)	College (1-4or 5+	F)		ent's Usual Occupation kind of work done during most of worki OO NOT use retired)				
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d oth	Be	17. Father's Nama (First, Middle, Last					ame (First, Middle			
is marked other aumatic event,	To	Philip J. Schr			Florer					
ELE		19a. Informant's Name/Relationship (. Mailing Address (Stre					
em 27 other tr		William J. It:	zel, Sr.		309 Woods		., Balt	.o., MJ	0 212	21
- to		20a. Method of Disposition		cemete	f Disposition (Name of ry, crematory or other p on Park C	olaca)	Date 8 - 4 - 98	Balto		
Important: If any Injury o once.		Sandure of Princel Service Licer The Control of Princel Service Licer Sandard Servi			Ambrose	Eunara 1	Home,	Inc.		us MD
/sician ledical		Immediate Cause (Final disease or condition	Ends	metrial	Cance	25				Interval Between Onsat and Dea
ledical aminer	niner	disease or condition resulting in death)	b	metrial Due to (or as a	Can ce consequenca of):	<i>'</i> '£				Interval Betwee Onsat and Dear
ledical aminer prival-transit	al Examiner	disease or condition resulting in death)	b	metrical Due to (or as a d	consequence of):	42				Interval Betwee Onsat and Dea
de the buriel-transit	Medical	disease or condition	b	metrical Due to (or as a d	Can ce consequenca of):	r				Interval Betwee Onsat and Dea
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 31, 1470 4c. County of Death William 10:30 PM Bnight SUL 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end numbar) 7. Age (In yrs. last birthday) If Under 1 Year Columbia, mo Howard Owney General 5. Social Security Number 6. Sax 7. Age 7. 10-09-0672 Howard If Under 24 Hrs. 8. Date of Birth (Month, Dey, NOV 9, 9. Birthplace (State or Foreign Country) TENNESSEE 5. Social Security Number Months Days 84 410-09-0672 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 S. Belle Grove Road 21228 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No. 1946/ If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Automotive Repair 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Charles William Knight Clemmie Lee Pearson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Belle Grove Rd. Catonsville, MD 21228 tion (Name of 20c. Location - City or Town, Stete Mary Elizabeth Knight/wife 20b. Place of Disposition (Name of cematary, cramatory or other pleca) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 8/3/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service L Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 299 Frederick Rd. Balti 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Iday Oromany or Due to (or as a consequence of): artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events rasulting in death) Last Bertensian Due to (or as a consaquanca of): Diabeto Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormed? 1 Yes 2 No 1 Tyes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA

Examiner Physician/Medical signed b p Completed Be

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ehow edical Examiner must be notified at

Director

Funeral

þ

Completed

Be

the Meryland

filed within 72 hours after death with

permit. Pages 1 and 2 should be filed within 72 ht. Department of Health end Mental Hygiene. Important: If item 27 la marked other than "natureny injury or other traumatic event, the Medical once.

Physician

/Medical

Baltimore, Maryland 21215-0020

/Medical

10a. State

is certificate has director, page 2:

2

Certification:

Medicai

27. Manner of Deeth

1 2 Naturel

29e. Certifier

Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certificately filled in by the funeral director; To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th

0

State Registrar 2 Accident 6 Could not be 3 Suicide 4 Homicide

5 Pending investigation

28a. Date of Injury (Month, Dey Year)

28b. Time of

1 ☐ Yas 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number D 34974

28c. injury at Work?

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

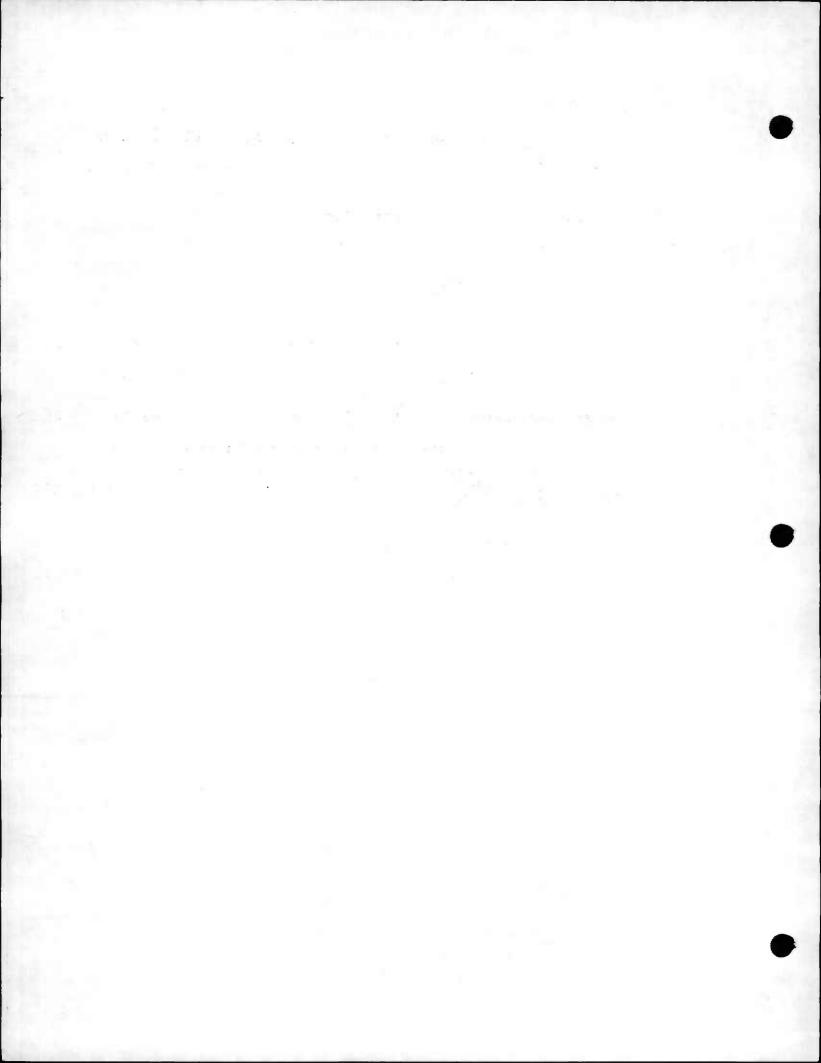
8775, Cloudleap ct, #224, Columbia, MD 21045

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

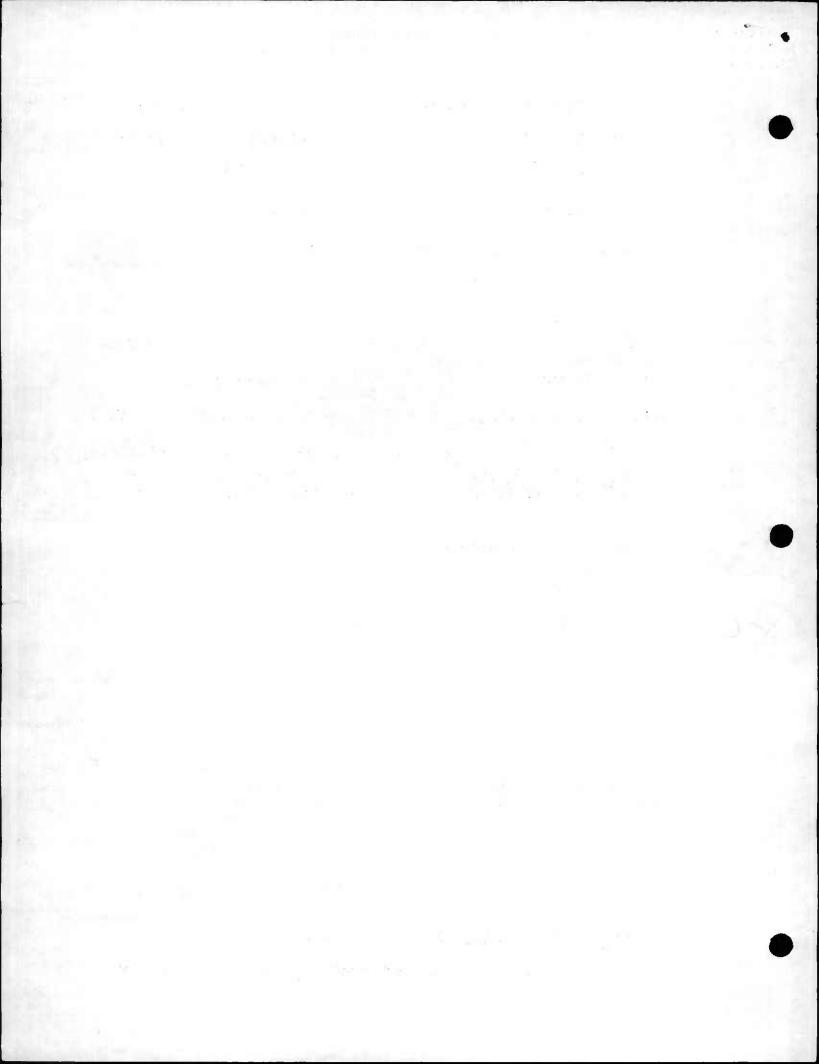
AUG

32. Registrar's Signatura Julia Davidson-Randell



	Decedent's Name (First, Middle, Last)		Department of H	Death	Reg. No.	3. Time of Death
Physician /Medical	Kathleen 4a Facility Name (If not institution, give	Michelle Kre			JLY 27, 199	Yeer 4:50 PM. ty of Deeth
Examiner	5908 ST. MARY'S			WOODLAWN		TIMORE
Funeral Director	5. Social Security Number 6. Se 214-90-4591 Usual Residence of Decedent	7. Age (In yrs. let	st birthday) If Under 1 Year Months Days		te of Birth	9. Birthplace (State or Foreign Country) Maryland
ural", or items 23a or 28a-f show at Examiner must be notified at ed by Funeral Director	MD 10b. County Baltim		Town or Location Owings	Mills		10d. inside Clty Limits 1 ☐ Yes 2 🕅 No
r froms 23a or 23a-f s iner must be notified Funeral Director	10e. Street and Number 4 Regalia Co	urt Apartmer	nt B 10f. Zip Code 21	.117		f Whet Country? USA
leted by Funer	11. Marital Status 1 ☐ Never Married 2 ☒ Marrled 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. 13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	tispanic Origin? (Specify Yo an, Mexican, Puerto Rican, Specify:		ece - American Indien, leck, White, etc. ify: White
Be Completed	15. Decadent's Edu (Specify only highest grad Elementery/Secondary (0-12)	College (1-40r 5+)	16e. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire Homemaker	petion during most of working d)		Business/Industry Home
To Be C	17. Father's Name (First, Middle, Last) Victor Thompso	on		18. Mother's Name (First Kathlee		ame)
E .	19e. Informant's Name/Relationship (T)		19b. Mailing Address (Street			
or other	Bradley Scott Kres 20e. Method of Disposition 1 Burial 2 Ocermation 3 F 4 Donation 5 Other (Specify)	Removal from Stete	5908 St. Mar oce of Disposition (Name of metery, crematory or other pla ro Crematory,	ce) Dat	e 20c. Location	21207 - City or Town, State cimore, MD
any injury page		regorchik	22. Name end Addre Crematio 299 Fred	erick Road	of MD, In Baltimor	nc. re, MD 21228
ician dical	23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the death. ne cause on each line.	Do not enter the mode of dyli	ng, such as cardiac or resp	iratory errest,	Approximate interval Between Onset end Death
	Immediete Ceuse (Final	DDODO	VVDUCNE THEORE			
niner	Immediete Ceuse (Final disease or condition resulting in death)	θ	OXYPHENE INTOXICAT	TION		
	disease or condition	θ	OXYPHENE INTOXICAT	TION		
Examiner	disease or condition resulting in death) Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying	Due to (or a	es a consequence of): as a consequence of):	FION		
edical Examiner	disease or condition resulting In death)	Due to (or a	es a consequence of):	FION		
Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	Due to (or a Due t	es a consequence of): as a consequence of): as e consequence of):		3b. Did tobacco uae c 1 □ Yes 2 ☑ No	contribute to the cause of death?
Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Due to (or a Due t	es a consequence of): as a consequence of): as e consequence of):	ven In Part I. 2		3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause
mpleted by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Due to (or a Due t	es a consequence of): as a consequence of): as e consequence of):	ven In Part I. 2	1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to
entitions has been signed by the alternoring projection, and poton, pages 2 should be detached for use as the bunchinans! Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions condit	Due to (or a Due t	es a consequence of): as a consequence of): as e consequence of): ting in the underlying cause give	ven in Part I. 2 2- 26. Piece of Death (Che	1 Yes 2 No	3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No
his centificate has been signed by the attending plysible, and all director, page 2 should be deteched for use as he bunshiransit. To Be Completed by Physician/Medical Examiner.	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions condi	Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a d	es a consequence of): as a consequence of): as e consequence of): ting in the underlying cause given	ven In Part I. 2 26. Plece of Death (Chener: 4 □ Nursing Home 5	1 Yes 2 No	24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 1 Yes 2 No Note (Specific Sidence)
his centhate has been signed by the attending physiting and attended to use as the bunchinanal. To Be Completed by Physician/Medical Examiner.	disease or condition resulting in death) Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions conditions conditions conditions conditions. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pending investigation	Due to (or a Due t	es a consequence of): as a consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as a consequence of):	ven In Part I. 2 26. Plece of Death (Chener: 4 □ Nursing Home 5	1 Yes 2 No 4a. Was an autopsy performed? 1 Yes 2 No ck only one) 1 Residence 6 XO	24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 1 Yes 2 No Note (Specific Sidence)
and bit sections. After this certificate has been signed by the attending physical and the bit in by the funeral director, page 2 should be deteched for use as the burnhianast ded in by the funeral director, page 2 should be deteched for use as the burnhianast Certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions condit	Due to (or a Due t	es a consequence of): as a consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as e consequence of): as a consequence of):	26. Plece of Death (Chener: 4 Nursing Home 5 ry at 14 Yes 2 00 No 28f. Lc	1 Yes 2 No 4a. Was an autopsy performed? 1 Yes 2 No 6ck only one) GResidence 6 No escribe how injury occ UNKNOWN coation (Street end Nurity or Town, State) 5 S BALTIMORE	24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No Ther (Specific estimates) There or Rurel Route Number, MARY LAND
in 24 hours also deauth as the certificate has been signed by the attending provides and pletely filled in by the funeral director, page 2 should be detached for use as the bunchhanat edical certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions condit	Due to (or a Due t	es a consequence of): as a consequence of): as a consequence of): as e consequence of): as e consequence of): as e consequence of): as a consequence of):	zen In Part I. 2 26. Plece of Death (Chener: 4 \sum Nursing Home 5ry at rk?) Yes 2 X No 28f. Lc Ci	1 Yes 2 No 4a. Was an autopsy performed? 1 Yes 2 No 6ck only one) 6 Residence 6 Mo escribe how injury occ UNKNOWN coation (Street end Nur ity or Town, State) 5 BALTIMORE, ite to the ceuse(s) end it	3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No Other (Specific Street Number, Polymer or Rure! Route Number, Polymer of MARYLAND) menner es steted.
The state of the s	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Pert II. Other significant conditions con	Due to (or ed.) Due to	BY/Outpatient 3 DOA Other Down of the University of DOA OUND: 2:25M DOA OTHER DOWN OF THE NEW OWN OF THE NEW OWN OF THE NEW OWN OF THE NEW OWN OF THE NEW OWN OF THE NEW OWN OF THE NEW OWN OWN OF THE NEW OWN OWN OF THE NEW OWN OWN OF THE NEW OWN OWN OF THE NEW OWN OWN OWN OWN OWN OWN OWN OWN OWN OW	26. Plece of Death (Chener: 4 Nursing Home 5 ry at rk?) Yes 2 X No 28f. Lc Ci	1 Yes 2 No 4a. Was an autopsy performed? 1 Yes 2 No 6ck only one) 3 Residence 6 No escribe how injury occ UNKNOWN cotation (Street end Nurrity or Town, State) 5 BALTIMORE, te to the ceuse(s) end in the time, date end plece	3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No Other (Specific Street Number, Polymer or Rure! Route Number, Polymer of MARYLAND) menner es steted.

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month **Physician** 3:30 AM Leslie Earl Kern Jr. August 2, 1998 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Chesapeake Hospice Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. 8. Dete of Birth
(Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 X M 2 □ F Vrs 217-22-1638 71 **Director** Jan 16 1927 MD Usuel Residence of Decedent the Marylend 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County "nature", or items 23s or 28s-f show adical Examiner must be notified at 1 Yes 2 No MD Anne Arundel Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with 1 Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturef", or itema 23a or any injury or other traumatic event, the Medical Examinet must be a 9149 Fort Smallwood Rd USA 21122 Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ⊠ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Accountant Concrete 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Leslie Earl Kern Agusta M. Bruns 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia Andercyk /daughter 9149 Fort Smallwood Rd Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Aug. 3 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 N Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Metro Crematory Catonsville, MD ^{22, Name end Address of Fecility}
Connelly Funeral Home of Dundalk 21. Signature of Funeral Servica Licenses 7110 Sollers Point Rd 23a. Pert1. Enter the describe, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Do not enter the mode of dying, such es cardiac or respiretory errest, **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical 4 yooss Chronic rena Examiner Due to (or es e consequence of): Physician/Medical Examiner 058174 ersonic Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): The law requires that the deeth certificate be Ischen MO Due to (or as e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24e. Was en eutopsy ils certificate has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hoope Co 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: Attending 5 Pending investigation 1 Naturel death. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, offica building, efc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Director: After this Hospital or Al 24 hours after edicai

Records, P.O. Box 68760 Division of Vital To the Hospital o within 24 hours aff To the Funeral Di completely filled in

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) 29c. License number

D4497

29b. Signature and title of certifier MD 29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

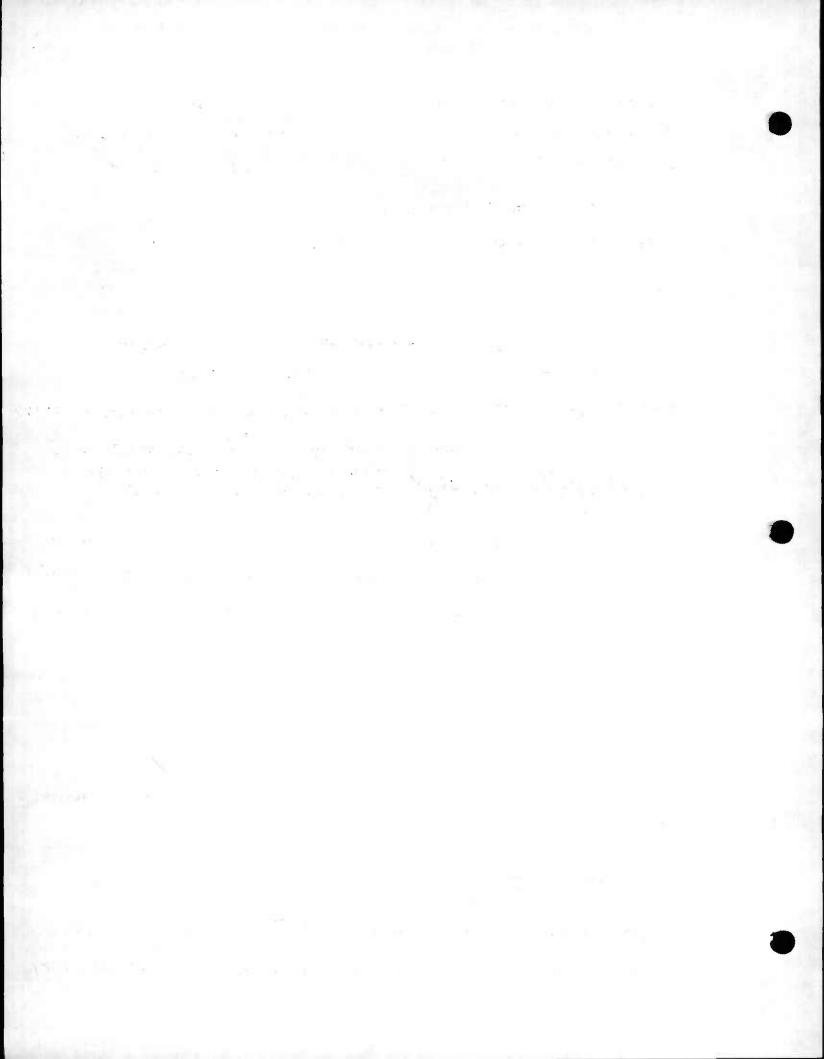
3 1998

GURMEETS SAWHNEY MD, 325 HODPITALDR. CLEN BURNIE MD 21061. 31. Dete filed (Month, Dey, Year)

State Registrar 29a. Certifier (Check only one)

AUG

32. Registrer's Signature which Davidson-Randall



WRC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 98-4441-510 State of Maryland / Department of Health and Mental Hygiene HAZEL 23469 KOBER Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev **Physician** JULY 31, 1998 HAZEL ELIZABETH KOBER 6:06 PM. /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** BALTIMORE
If Under 24 Hrs. 8, 0 121 N. HIGHLAND AVE. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthpiece (State or Foreign Country) **Funeral** Deys 1□M 250 F Yrs. 91 Director 218072877 MAY 29, 1907 MARYLAND Usuel Residence of Decedent the Marylend 10e. State 10c. City, Town or Location 10d. inside City Limits 10b. County tem 27 is marked other than "natural", or fema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 121 N. HIGHLAND AVENUE death Funeral 21224 14. Raca - American Indien. 12. Wes Decadent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours efter Depertment of Health and Mental Hygidene. Important: If item 27 is marked other than "natural", or has any Injury or other traumation. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 2 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME 6 0 HOMEMAKER 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be UNK. BORTNER UNK. HMK 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD 21237 ALBERT STACK / SON-IN-LAW 8009 EDGEWATER AVE Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/4/98 MIDDLE RIVER, MD HOLLY HILL 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 Approximete Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Arteriosclerotic Cardiovascular Disease Immediate Ceuse (Final disease or condition resulting In death) /Medical Examiner Due to (or es e consequence of): Examiner physician and s the buriel-trensit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events Due to (or es e consequence of): P.O. Box 68760 certificate be Physician/Medical Due to (or es e consequence of) resulting in deeth) Lest USB BS signed by the attending d be detached for use ea Part II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been significant 24e. Wes en eutopsy performed? Completed pege 2 s INSPECTION 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitei Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1⊠ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this by the funeral Date of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation Injury or Attending setter deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 I Homicide the Hospital of thin 24 hours of the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

2 Nedical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical

State Registrar 29b. Signeture and title of certifie

31. Dete filed (Month, Day, Yeer)

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 32. Registrats Signature

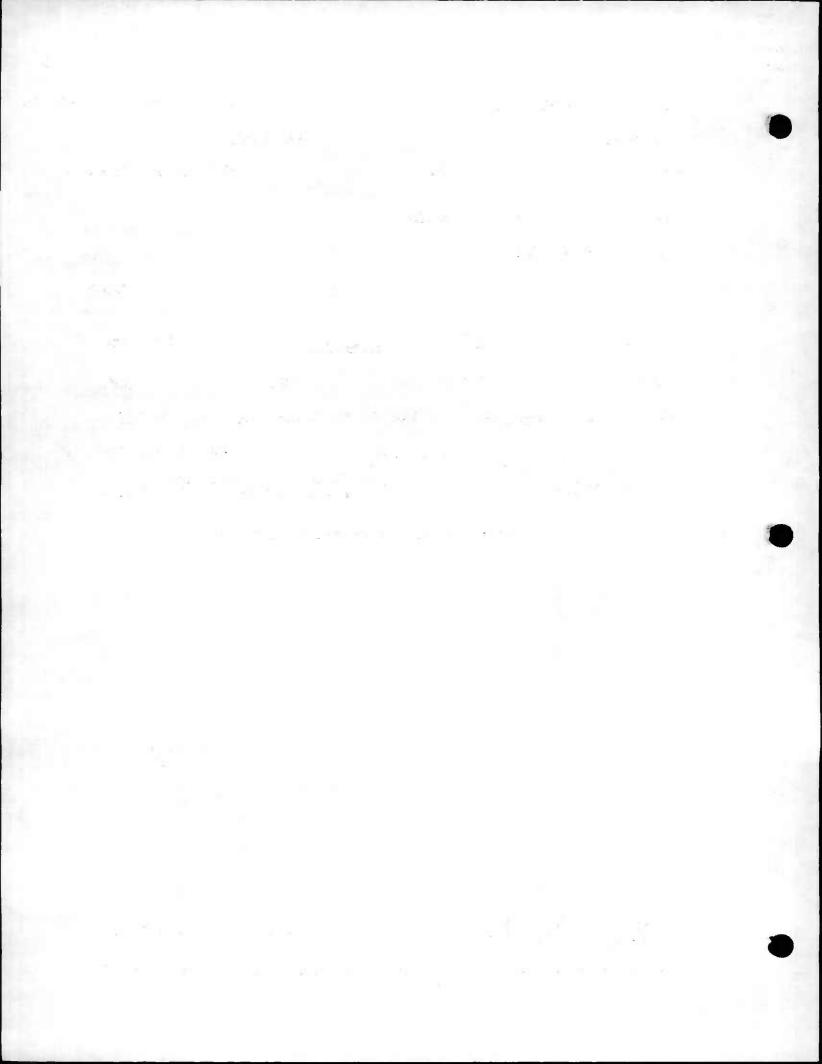
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

O.C.M.E.

29d. Date signed (Month, Dev. Year)

AUGUST 01, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Tima of Death 2. Date of Deeth Kertha 4a. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore City Good Baltimore Samaritan Hosp 0+ If Undar 24 Hrs. 8. Date of Birth (Month, Day, May 12, If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) 6. Sax Months Days 1 M XXF 1906 92 Maryland 216-42-8017 Usual Residence of Decedant 10a, Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ¥Yas 2 ☐ No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizan of What Country? 801 N. Kenwood Avenue 21205 USA 12. Was Decedant Evar In U,S Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 No If Yas, Give Yaar or Datas: 1 ☐ Yas XX No Specify: Specify: White ₩idowed 4 Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 6th Homemaker Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Stanley Kowalewski Mary Ann Piorkowski 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Louis J. Kawalek / Son 801 N. Kenwood Avenue Baltimore, Maryland 21205 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 8/3/98 Baltimore, Maryland 21. Signature of Funeral Service Li 22. Nama and Addrass of Facility David J. Weber Funeral Home 401 S. Chester St. Baltimore, Maryland 21231 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Immediata Causa (Final disaesa or condition rasulting in daath) neu mo ma Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseesa or Injury that Initiated avants rasulting In daath) Last Dua to (or as a consaquance of): Dua to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa coptributa to the causa of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy complation of cause of daath? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical axaminer? 26. Placa of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Spacify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA 27. Manner of Daath 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral', or items 23a or 28a-f shov Examiner must be notified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or ther any injury or other traumatic event, the Mentel I.

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

The law requires that the death certificate be executed ettending physician and for use as the buriel-tran á page 2 should peen this certificate has

Box 68760,

P.O. I

Records,

Division of Vital

Physician/Medical Examiner

þ

Completed

Be

Medical Certification: To

3 Suicida

29a. Certifier (Check only

560

4 Homicide

29b. Signature and Jith of certifier

31. Data filad (Month, Day, Year)

tung

AUG

Attending Physician: Director: After this certific d in by the funeral director, death. after after To the Hospital of within 24 hours at To the Funeral D completely filled

Registrar

State

5 Pending invastigation 1 Neturel 2 Accident

30. Name and oddress of person who completed cause of death (Item

1998

och

6 Could not ba

32. Regist

28a. Date of Injury (Month, Day Yaar) Injury

who Davidson

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

23a) (Type, Print)

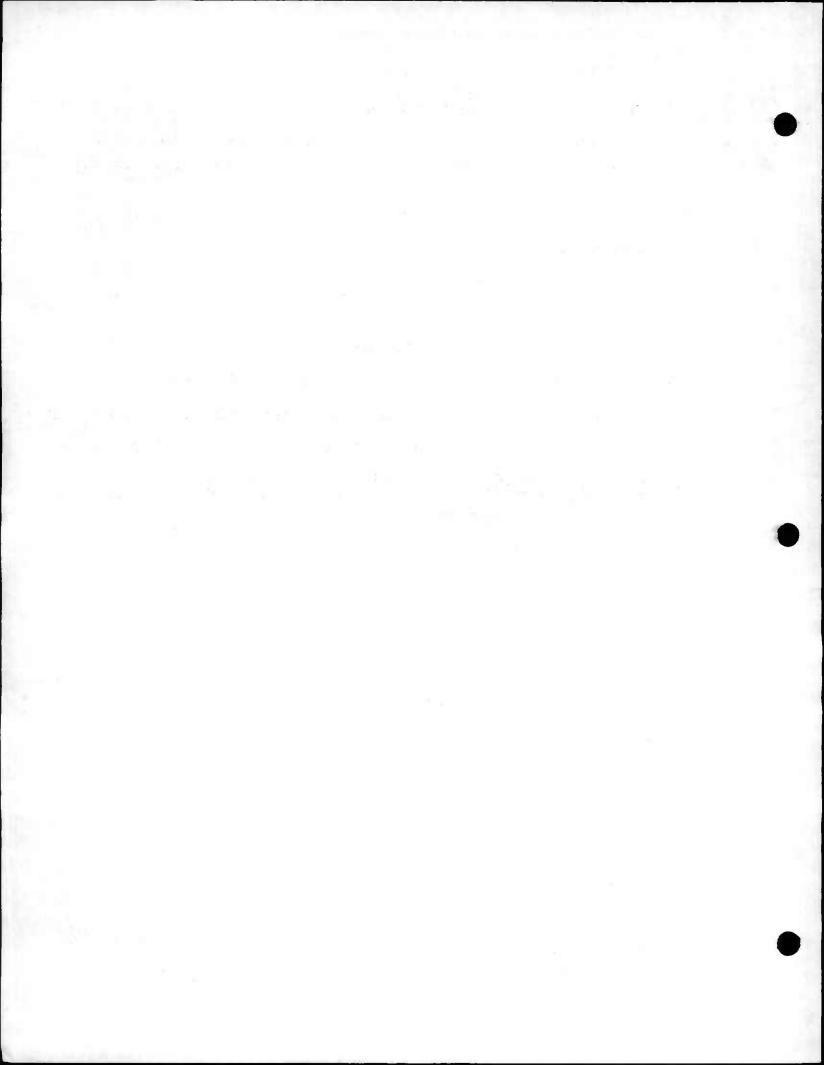
1 ☐ Yas 2 ☐ No

28f. Location (Streat and Numbar or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) end mannar as statad.
2 Madicat Examinar: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) and mannar statad. 29c. Licansa number

29d. Data signad (Month, Day, Year)

Baltimore,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#23apt1,29c per Phy G762 8/3/98 EW 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margaret 7.30 pm Kennedu 1717 1998 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Bon Secour Hospital Baltimore Baltimore City 8. Date of Birth (Month, Day, Young 10, If Under 1 Year 9. Birthplece (Stete or Foreign Country) Maryland 7. Age (In yrs. last birthdey) If Under 24 Hrs. 5. Social Security Number Hours Days Months 1 M 2 TF 75 217-12-3667 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Maryland Baltimore County 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 1 A. McIntosh Court 21228 U.S.A. 14. Rece - American Indian Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritel Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Physician's Office Bookkeeper 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Ellsworth Kirby Mary Edna Smith 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert F. Kennedy/husband 1 A. McIntosh Court, Baltimore, Maryland 21228 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 ☐ Other (Specify) 21. Signature of Fund Service Liberuse Director 22 Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 t1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Chronic Obstructive Pulmonary Desease Immediate Cause (Finel diseese or condition resulting In death) Artery Desease Due to (or es a consequence of):

Physician /Medical Examiner

Physician

/Medical

10e. Stete

Director

Funeral

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Completed

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Examiner

Funeral

Director

if Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer a Department of health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Item any Injury or other trauments event, the Mental Property.

the Maryland

death with

Examiner signed by the ettending physician end d be deteched for use as the buriel-trar Sequentially list conditions, if eny, leeding to immediate Physician/Medicai

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29b. Signature and title of adrillie

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1998

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Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest	d. Histor	or es e consequence of):	congestive	heart Fasher	e		
Pert II. Other significant conditions	contributing to death but not re	sulting in the underlying o	ause given In Part I.	23b. Did tobacco use co	ntribute to the cause of death		
				24a. Was en autopsy performed?	24b. Were autopsy findings eveilable prior to completion of ceuse of deeth?		
25. Was cese referred to medical	/		eath (Check only one)	(Check only one)			
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DC	me 5 Residence 6 Other (Specify)				
27. Manne of Death 1 Dataturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occur	red		
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, street, factory	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
				e, end due to the ceuse(s) and mourred et the time, date end plece,			

29c. License number

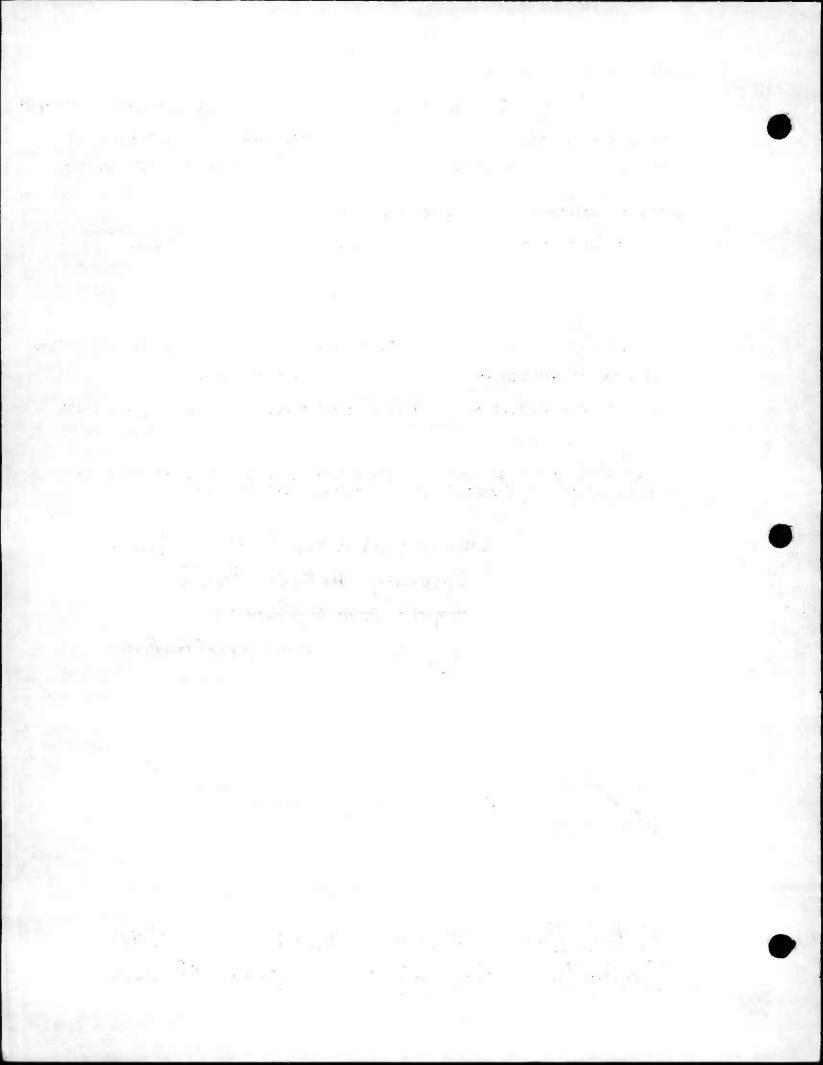
Baltimore MD

29d. Date signed (Month, Dey, Year)

07/17/98

Attending Physician: The lew requires that the death certificate be execut Division of Vital Records, P.O. tor: After this certificate hes been sithe funeral director, page 2 should Certification: To To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the f death.

> State Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Amelia Catherine King /Medical 4b. City, Town, or Location of Dead 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 K F 91 Yrs 220-01-2998 September 2 1906 Maryland **Director** Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Baltimore Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. #1009 21234 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be August Edward Shrader Weckesser Jeanette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Baltimore, MD 21234 Walther F. Nehrenz 8810 Walther Blvd. #1009 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 8/3/98 Loudon Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** newmonia Examir Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury and Due to (or as a consequenca of) that initieted events resulting in death) Last Due to (or as e consequence of): Physician/Med Pert 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COPD excerbation à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this is 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation 1 Naturel Injury 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Te the Hospital o within 24 hours at Te the Funeral Di completely filled in edical 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number July 31, 1998 Gow, M.D. AT 2438946

The Union Memorial Hospital, Baltmore M.D. 2/2/8

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

July Markette

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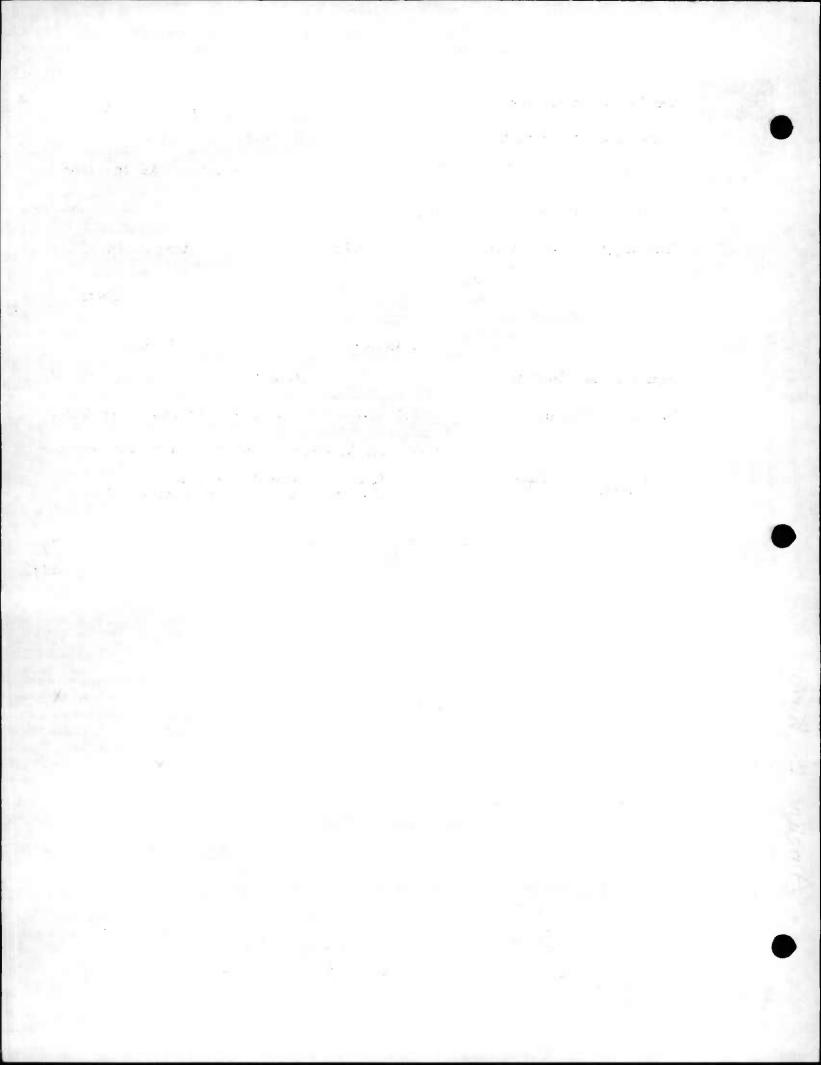
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DHMH 16 Rev 6/95

State Registrar

6

Amelia



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dev Month 14 Ey **Physician** 1645 Marilyn Virginia Liggins 28 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Union Memorial Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys 1 M 2 JAF Months 68 Yrs 218-26-2062 Director 06-01-30 Usual Residence of Decedent 10c. City, Town or Location 10e. State 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at YTYPes 2□ No. Director MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2113 Sinclair Lane 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: Saltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: Black p 8⊠Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Baltimore City 12th Grade NA Teacher Aide Public School 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) l end 2 should be fill lealth and Mental H m 27 is marked oth Be Claude Taylor Hattie Miller 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21213 19a. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2 Department of Health as Important: If item 27 is n Liggins 3864 Lyndale Avenue Baltimore, Maryland 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 07-31-98 Greenmount Cem. Baltimore, Md. 21. Signatura of Funeral Service Licensee 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Respiratory tailure Examiner Due to (or es e consequence of) Examiner neumonia Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) 68760 Physician/Medical Due to (or as e consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown BLA DDER CANSER 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy Anemia. 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medica 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA funeral 27. Manner of Death 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel ne Hospital or Attending in 24 hours after deeth. he Funeral Director: Afte 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) To the Vithin 2 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number

State Registrar VERONI CA
31. Date filed (Month, Day, Year)

AUG 3 1998

Veronico

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

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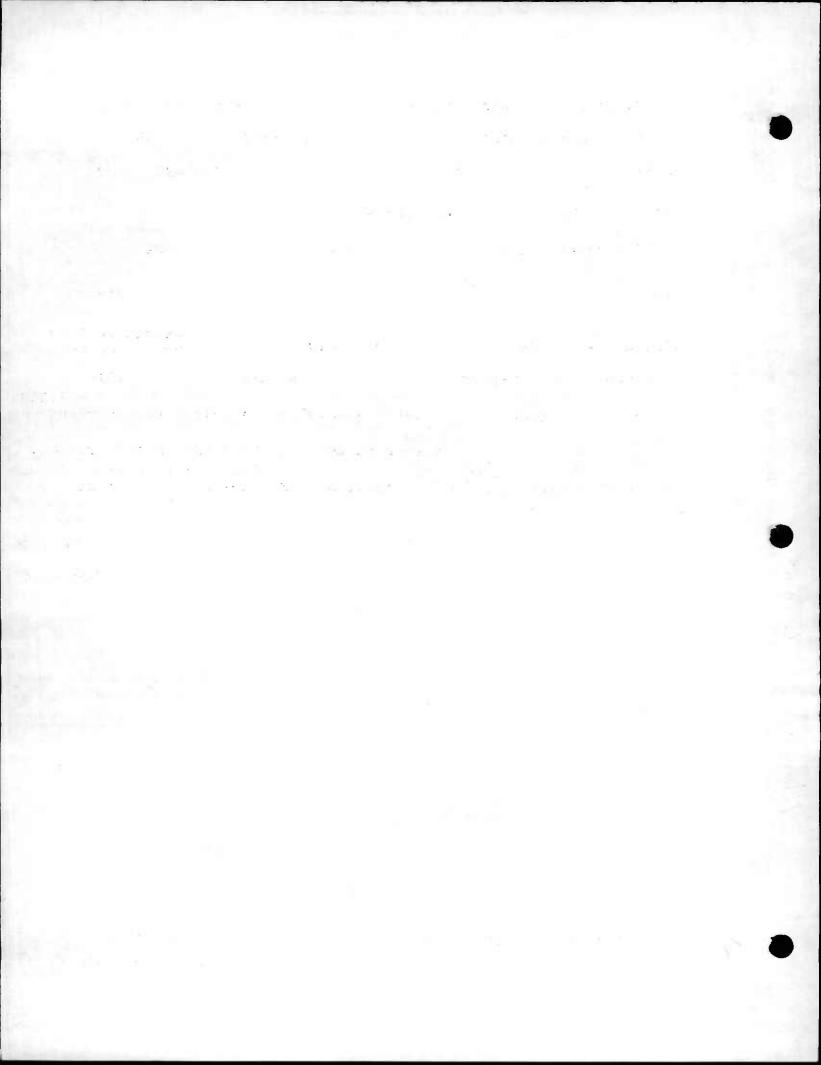
32. Registrer's Signeture

38. Savidson-Randall

EssLein

AT 2438946 July 28, 1998

UNION MEMORIAL HOSPTAY BALTO ND21218



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23474 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Month Day Yaar **Physician** 18:45 pm ALFRED (NMN) LARSEN JUL 31 1998 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner NIA BALTIMORE AGNES HEALTH CARE If Undar 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Funeral Days Months Hours 10 M 20 F 215-09-0247 Yrs. DEC 13,1904 Director 93 DENMARK Usual Rasidence of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified an once. 1 ☐ Yas 2 🗓 No MARYLAND BALTIMORE CATONSVILLE Direct 10e: Street and Number 10f. Zio Coda 10g. Citizan of What Country? 709 MAIDEN CHOICE LANE -FH-217 21228 Funeral U.S.A. Was Decedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indien, Biack, Whita, atc. 12. Wes Dacedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 1 YR ENGINEER GLEN L. MARTIN COMPANY 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be LAURITS LARSEN KRISTEN JUSTESEN 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 3337 L. NO. CHATHAM ROAD - FLLICOTT CITY, MD 21042 20b. Place of Disposition (Name of cemelary, cramatory or other place) Data 20c. Location - City or Town, Stata CHRISTINE CLARK (DAUGHTER) 20a. Mathod of Disposition 1 Surial 2 Cramation 3 Ramoval from Stata ST. JOHN'S CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 8/4/98 ELLICOTT CITY, MD. 22. Nama and Addrass of Facility HUBBARD FUNERAL HOME INC. 21. Signatura of Funa Sarvice Licensas resa 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23a. Part T. Entar tha disaasa, or complications that ceusad tha dauth. To not anter tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Approximate Interval Batwaan Onsat end Daath Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 5 days Preumonia Examiner Dua to (or as a consaquance of): Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initialed avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? Completed 24a. Was an autopsy 1 Tyes 2 No 1 Yas 2 No 25. Was casa rafarrad to medical Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Spacify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Straet and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicida 29a. Cartifiar 1 🗷 Certifying Phyaician: To tha bast of my knowladga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

29c. Licansa number

Ave.

10879

Baltimore

29d. Date signed (Month, Day, Year)

31 1998

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July

MD

The law requires that the death certificate be executed Records, P.O. Box 68760 s been signed by t should be detach page 2 certificate Division of Vital Attending Physician: funeral director, ALFRED After this To the Within

attending physician and for use es the buriel-transit

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Registrar

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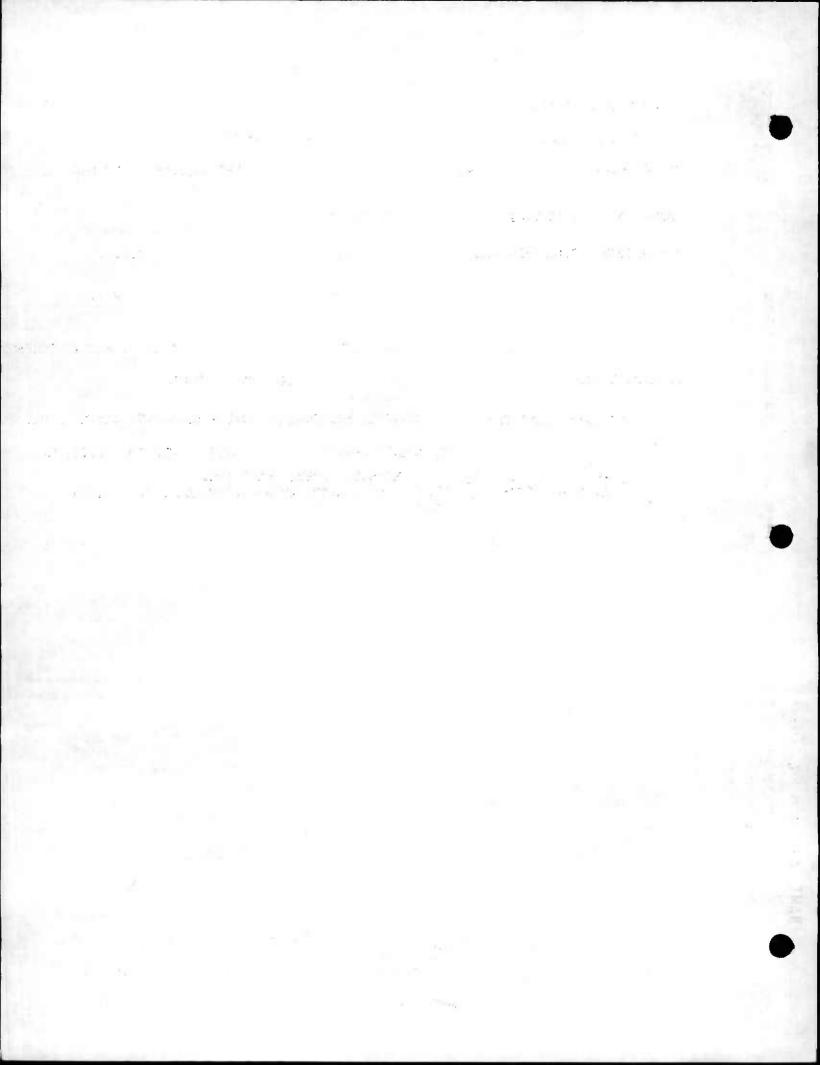
Herminio Oxedo MD

30. Name end eddress of person who comprehed ceusa of daath (Itam 23a) (Type, Print)

29b. Signeture end titla of certifier

Caton 32. Registrar's Signatura Davidson-Randell

DHMH 16 Rev 6/95



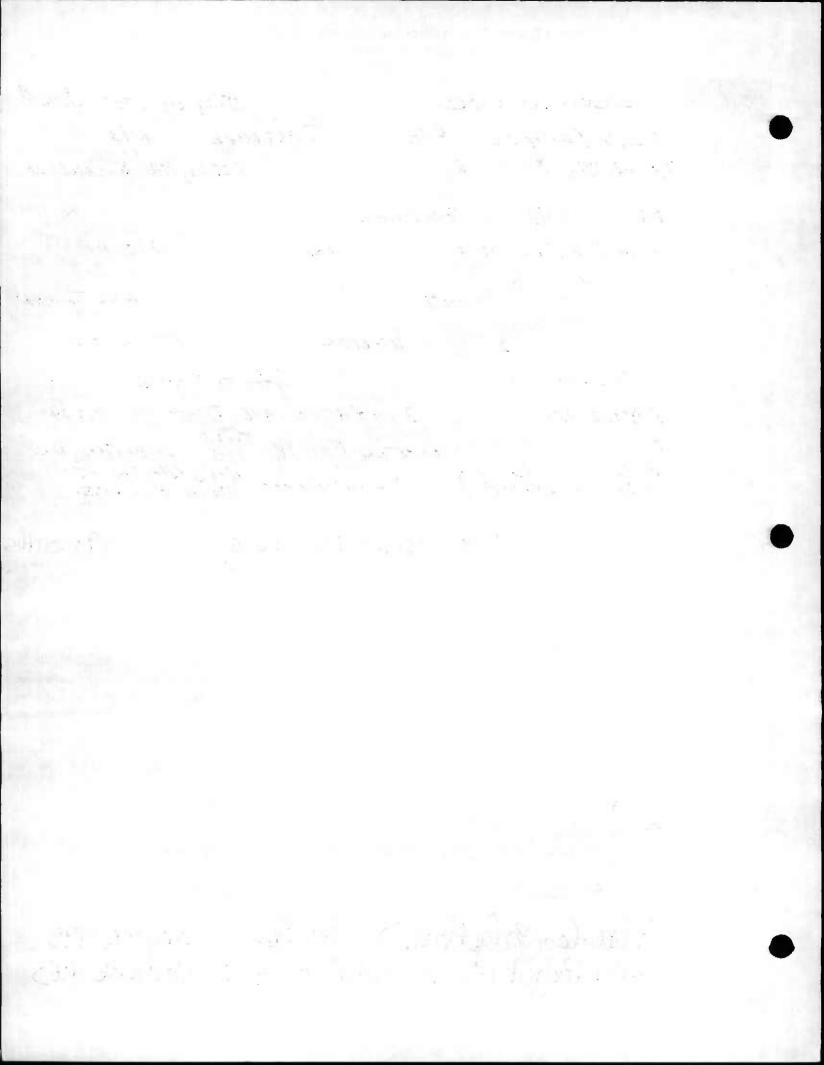
State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) **Physician** NUOL 00 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EAS 1E TIMORE If Under 24 Hrs. H Under 1 Year 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days 246 - 48 - 3786 Usuel Residance of Dacedant M 2□ F Director death with the Marylend 10b. County 10a State 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A Funerai 12. Was Decedant Evar In U.S. Armed Forcas? 1 12 Yas 2 1 No 11 Yas, Giva Yaar or Dates: 14. Race - American Indian, Black, Whita, atc. 13. Was Decedant of Hispenic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. I have a fired other than "natural", or ther any Injury or other traumatic event 1 Naver Marriad 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify Specify AMER INDIAN þ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) SHIPBUILDING WELDER 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be ပ 19b. Mailing Addrass (Streat and Number or Rural Routa Number/City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Typa, Print) BALTO-MD 20a. Mathod of Disposition Date 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Spacify) Wh 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onsat and Daath **Physician** /Medical fmmediate Causa (Final disaasa or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 98 signed by the et id be detached fo 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Xyas 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings eveilabla prior to complation of causa of daath? Completed 24a. Was an autopsy performed? peen page 2 s hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Attending Physician: funeral director, 25. Was casa rafarrad to medical Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1º 1 Yas 2 No 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred actor: After 5 Pending investigation 1 SNaturat 1 Yas 2 Accident 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a, Cartifiar (Check only 29b. Signature and title of o 29c. Licensa number 29d. Data signed (Month, Day, Year)

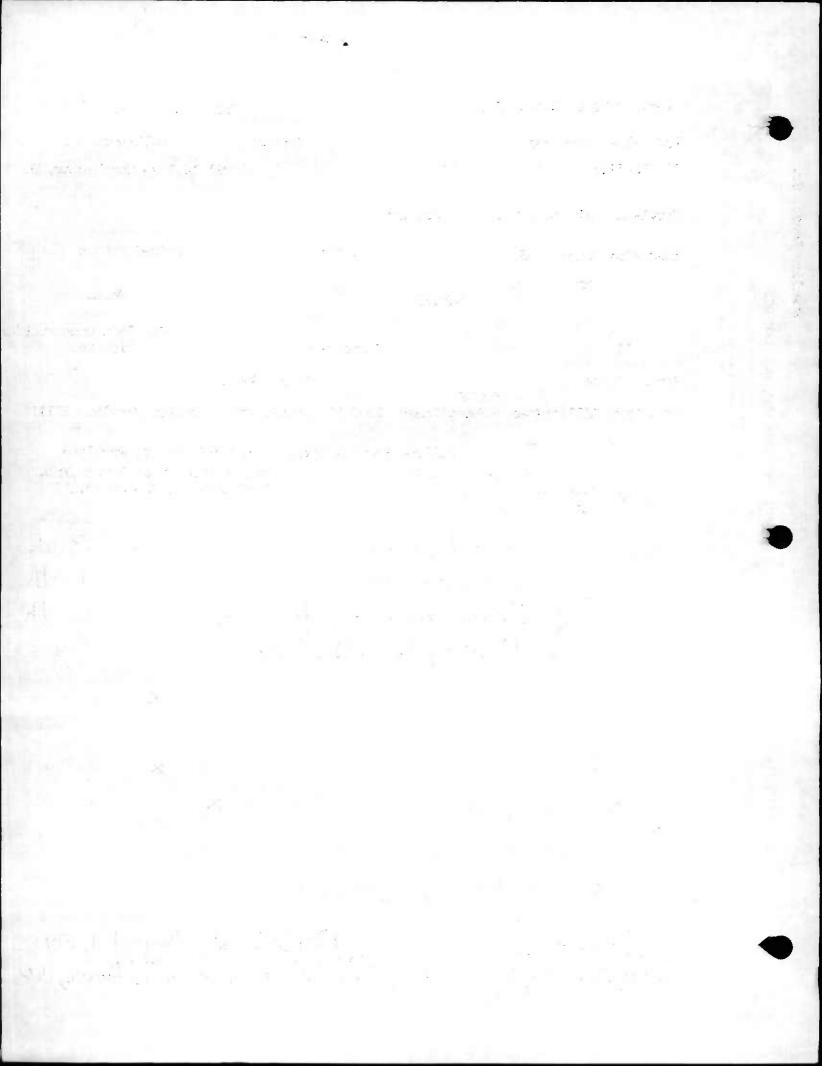
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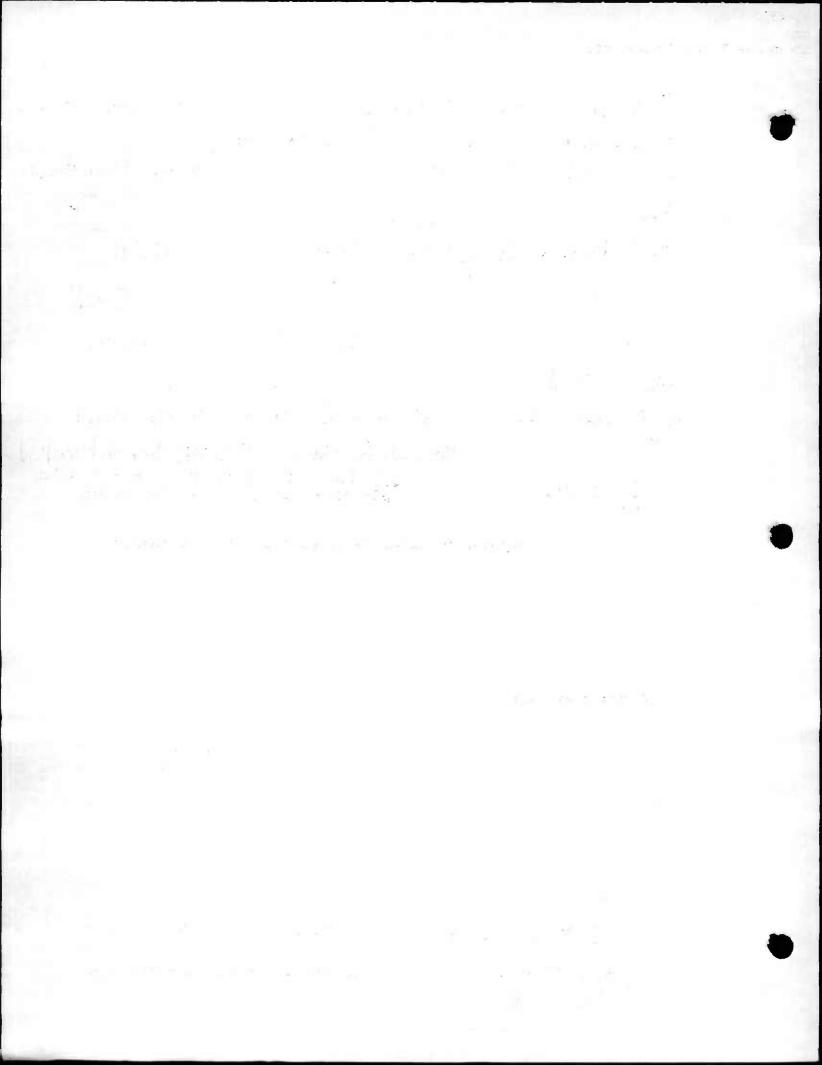
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hysician	1. Decedent's Name (First, Middle, Last)		2	Data of Death Month	Day	Year .	me of Death 05 PM			
al	Sterling Lamar Leese, Sr. 4a Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	July 3	1, 19 4c. County	998	US PM			
iner I	1300 Blue Mount Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-12-5732 1XI M 2□ F 73 Yrs.	Date of Birth (Month, Day, Ye Oril 14,	Baltimore Co of Birth th, Day, Year) 9. Birthplace (Souther) Country (Souther) 1 14,1925 Manchest							
or	Usual Rasidanca of Decedent 10a. State 10b. County 10c. City, Town or Loc Maryland Baltimore Co. Monkton					lde City Limits				
Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of V	Vhat Country?				
	1300 Blue Mount Road	ı	U	nited	States	States				
	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes. Give 1 □ Yes Give	21111 √as Decedent of Yes, specify Cult □ Yas 2₺ No	Hispanic Origin? (Speci ban, Maxican, Puerto Ri	y Yes or No- can, etc.)	Blac	e - American Ind k, White, etc. White	American Indian, Vhite, etc.			
	3 ☐ Widowed 4 ☐ Divorced Year or Dates: W.W. II	ant's Usual Occu	voetlon	161		WILL CE				
	(Specify only highest grade completed) (Give k Elamantary/Secondary (0-12) College (1-4or 5+)	and of work done NOT use retire Carpente	during most of working ed)	100	Fing.	lass Cor tion Co.				
	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Mai						
	Ernest Leese		Annie The							
	Mrs. Mary Lillian(nee McKevey)Leese	1300 Blu	at and Number or Rural I De Mount Ro	ad Monk	ton,M	aryland	21111			
	20a. Method of Disposition 1 ☐ Burial 2XICremation 3 ☐ Removal from State 20b. Place of Dispose cametery, crem					City or Town, St				
	4 □ Donation 5 □ Other (Specify) Hilltop S 21. Signature of Funeral Service Licensee Teffrey L. Gair 22.			03/98 To						
	al Home, son,Md.2									
	23a. Part T. Enfer the disease or complication, that caused the death. Do not enter shock, or heart failure list only one cau won each line. Immediata Cause (Final disease or condition resulting in death) Due to (or as a consequence)	ire				Intarv	al Batween t and Death			
Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last d. Multiple	pance of):	ploma			5	my hs			
1	Part II. Other significant conditions contributing to death but not resulting in the un	dariving cause o	iven In Part I.	23b. Did toba	cco uae cor	ntribute to the c	ause of death?			
				23b. Did tobacco use contribute to the cause of deal						
,				24a. Was an a performed			prior to on of cause			
				1 □ Yes	2 No	of daath?	2 No			
	25. Was case referred to medical		26. Placa of Death (-7-4.0					
	examiner? 1 Yes 2 No	3LI DOA	ther: 4 Nursing Home	5 Residence	a 8 🗆 Oth	er (Specify)				
	27. Manner of Death 1 Natural 5 Panding (Month, Day Year) 2 Accident Investigation 2 Could not be		Yes 2 No	d. Describe how						
	3 ☐ Suicida 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stra building, etc. (Specify)	eat, factory, office	28	f. Location (Stree City or Town, S		er or Rural Rout	e Number,			
edical	29a. Certifier (Check only one) Certifying Physician: To tha best of my knowledge, death 2 Medical Examtner: On the basis of examination and/or invariant manner stated.	occurred at the t estigation, in my	time, date and placa, an opinion, death occurred	d due to the caus at tha time, date	e(s) and ma and placa,	annar as stated. and due to the c	ausa(s)			
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day 29d. Date signed (Month, Day 29d. Date signed (Month, Day									
	30 Many and didees of person who completed cause of death (Item 23a) (Type, F	Print) Debo	rah C. I	Marcel Volle Si	lad	mo. altimor	mn			



Ernestine Elizabeth Lawrence

			State of Mary		ate of Death	Reg. No.	98 2	34//				
		1. Decedent's Name (First, Middle, L	ast)			2. Dete of Deeth Month Dey	Yeer	3. Time of Death				
	Physician /Modical	Ernestine	Elizobeth (Musical		July 30	1998	6:59 A.M.				
	/Medical Examiner	4e Facility Neme (If not institution, g	ive street end number)		4b. City, Town, or Lo	The latest the latest	County of Deeth					
		1400 E. Madison	St., apt. 511		Baltimo	re						
F	uneral		Sex , 7. Age (In)	yrs. lest birthday) If Uni	der 1 Year If Under 24 Hrs.	8. Dete of Birth (Month, Day, Year)	9. Birthp	plece (State or Foreign				
D	irector	227-26-8288	1 □ M 2 1 F	70 Yrs.		3 6 28	5 Nor	th Landlina				
9		Usual Residence of Decedent 10a, State 10b. County	100	City, Town or Location			1	0d. Inside City Limits				
laryta	at at	MJ 100. County	100	2 11			,	1 2 Yes 2 □ No				
2	be notified Director	110		Jaltima	9	10- 0:4	zen of Whet Coun	711 742 7 7 7				
6	D 20	10e. Street and Number	(1)	5.1	Zip Code	log. Citi	1 0	nry r				
- 6	e 23	1900 E. Madis	on ut., upt	· 311 6	ALOUD	asibi Yas as No	14. Reca - Americ	en Indian				
- 6	ritems 23s or 28sef show siner must be notified at Funeral Director	11. Maritel Status 1 Never Married 2 Married	12. Wes Decedent Ever in Armed Forces?	If Yes, s	cedent of Hispenic Origin? (Sp pecify Cuben, Mexicen, Puerto	Ricen, etc.)	Bleck, White,					
00020 hours at	Exami		If Yes, Give Yeer or Detes:	1 ☐ Yes	2 No Specify:		Specify:	nk				
9 2				16e. Decedent's U	suel Occupation	16b. Ki	nd of Business/Inc	dustry				
215-	t, the Medical	(Specify only highest g	rade completed)	(Give kind of life. DO NO)	work done during most of work	ring						
2121 3 within	the me	Elementary Secondary (0-12)	College (1-4or 5+)		tomeinaker		omest	10				
Dd 2	a dother event,	17. Fether's Neme (First, Middle, Las	it)			e (First, Meddle, Maiden	Sumame)					
rlan	To E	Wesh Datt	P		Joann	Reed						
Maryland 21215-0020 nd 2 should be filled within 72 hours at		19a. Informent's Name/Reletionship	(Type, Print)	19b. Mailing Addr	ess (Street and Number or Run		r Town, Stete, Zip	Code)				
- No. 1	27.4	to L. bres-	Niere	21 lato	e Cr. Owir	as Mill M	ld. 211	117				
ore	and and and and and and and and and and	20a. Method of Disposition		b. Place of Disposition (f	Verne of		cation - City or To	own, Stete				
altimore,	# 50 m	1 M Burial 2 ☐ Cremetion 3 4 ☐ Donetlon 5 ☐ Other (Spec		aschell Ce	maleni	3.5.98/3/	timine.	Maryland				
E #	ario a	21. Signature of Funeral Service Lic	ensee	22 Name	and Address of Pacility		und e	- majoria				
00 1	5550	(m.00.		Left	Miller P.C.	LANGUA H	ome &	Jeno 1002				
		23a. Part1. Estat he diseese, or co	mplications that caused the c	leath. Do not enter the m	node of dving, such es cardiac	or respiretory errest.	10.019	Approximate				
Dh	ysician	23a Part Entre he diseese, or co	y one cause on each line.					Intervel Between Onset and Deeth				
	ledical	Immediate Ceuse (Finel	Itmontonai	vo Artorios	alamtia Cardi	ovecouler I)iceace					
Hai	attituet	disease or condition resulting in deeth)	e		clerotic Cardi	LOVASCUTAL I)ISCOSC					
-	و الكلية		Due	to (or es e consequence	or):		1					
peta	iel-transit Examiner	b. Due to for as a consequence of the										
- Å	buriel-transit ai Examir	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or es e consequence of):										
68760 ficate as	g physical as the bur edical											
	as th	resulting in deeth) Last										
Box	attendin for use		d									
. 0	d by the attending etached for use a Physician/M	Pert II. Other significant conditions	contributing to death but not	g cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?							
0 8	ned by the a detached to y Physic	Diabetes Mel				1 ☐ Yes 2		bably 4⊠Unknown				
S, P	A D .	Didoctes fiel										
rd guire						24e. Was en eutop performed?	osy 24b. We	ere eutopsy findings eilable prior to				
Record he law require	2 sho						CO	mpletion of ceuse deeth?				
CC º	3 8 2					Inspection		☐Yes 2☐No				
	- O	25. Wes cese referred to medical	T		26 Place of Deat	th (Check only one)	Pilo	3.00 22.00				
of Vita Physician:		exeminer? 1 ☑ Yes 2 ☐ No	Hospitel:	2 ER/Outpatient 3		ome 5 Residence	R X Other /Snecil	wat scene				
	# H	27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year		28c. Injury at Work?	28d. Describe how injur		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
O de de	the fune	1 Moeturel 5 ☐ Pending 2 ☐ Accident investigati		r) Injury M	Work? 1 ☐ Yes 2 ☐ No							
Division	al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not	a 286. Piece of injury - A	At home, farm, street, fed	28f. Location (Street en	d Number or Rure	el Route Number,					
O P	din din	4 Homicide	building, etc. (Sp.	ecify)		City or Town, Stete)					
Hospital or	ai C				ed et the time, date end plece,							
e Ho	To the Funeral Directo completely filled in by the	(Check only 2 Medical Exp	aminer: On the besis of exemend menner stated.	nlnetion end/or Investiget	ion, in my opinion, deeth occur	red et the time, date end	place, end due to	the ceuse(s)				
To the	Me Me	29b. Signature and title of certifier			29c. License number		te signed (Month,					
		1 J. Puta	M.M.	THE PARTY	O.C.M.E.	July	y 30, 199	98				
	10	30. Name and address of person who	completed cause of deeth (Item 23e) (Type, Print)								
		Joseph Pes	taner		n Street, Balt	timore, Mar	yland 21	201				
	State	31. Date filed (Month, Day, Year)	- 1	Davidson-Rand								
	Registrar	AUG	3 1998 Dans	ramidon-Navo								

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) July 23, 1998 F. Loome 10:20 AM John 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) Deys Hours Months 1 M 2 □ F 83 Yrs. 267-34-7955 06/19/1915 Illinois Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Instde City Limits 1 ☐ Yes 2 ☑ No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2300 Dulaney Valley Road 21093 United States Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Arlington National Elementary/Secondary (0-12) College (1-4or 5+) President Race Track 5+ 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles S. Loome Marie Hanley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) Sr. Patricia Loome, S.N.D./daugh. 1531 Greenspring Valley Rd. Stevenson, MD 21153 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Conation 5 ☐ Other (Specify) Gate of HEaven Cemetery 7/28/98 Silver Spring, MD. 22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Park Effet the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart feiture. List only one cause on each line. Approximete Intarvat Betwaen Onset end Death Enest prifers Immediete Ceuse (Finat disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in daeth) Last Due to (or as a consequence of) SEYSVE Dua to (or es e consequence of) 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 1 Yes 2 No 3 Probably 4 JUnknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 XXXo 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

death with the Marylend

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinations must be notified

Baltimore, Maryland 21215-0020

/Medical

Directo

Funerai

þ

Completed

Be 10 MD

Physician/Medical Examiner physician end s the bunal-transit ettending p signed by the e þ Completed Be

0

Certification:

25. Wes case referred to medicat axaminer?

AUG

5 Pending investigation

6 Could not be determined

3 1998

1 ☐ Yes XXNo

27. Manner of Death

1 Accident

3 Suicida

29a. Certifier

4 Homicida

(Check only

requires that the death certificete be executed s certificete has t director, page 2 s director, funeral

P.O. Box 68760. Records, ve Hospital or Attending Physician: Th. 124 hours standard. of Vital

Medical To the Hosp within 24 he To the Fune completely f 24 hr Fune

29b. Signature and title of partifier. 29c. License number 29d. Date signed (Month, Day, Year) 26her ME 7.29 98 D 15504 30. Name and addrass of person who completed cause of deeth (Item 23e) (Type, Print) Eddie Nakhuda, M.D. 31. Date filed (Month, Dey, Year) 2300 Dulaney Valley Rd. Timonium, MD 32. Registrar's Signeture hie Davidson Randelle

28c. Injury at Work?

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end mannar as stetad.

2 Medical Examinar: On the basis of axamination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Dey Year)

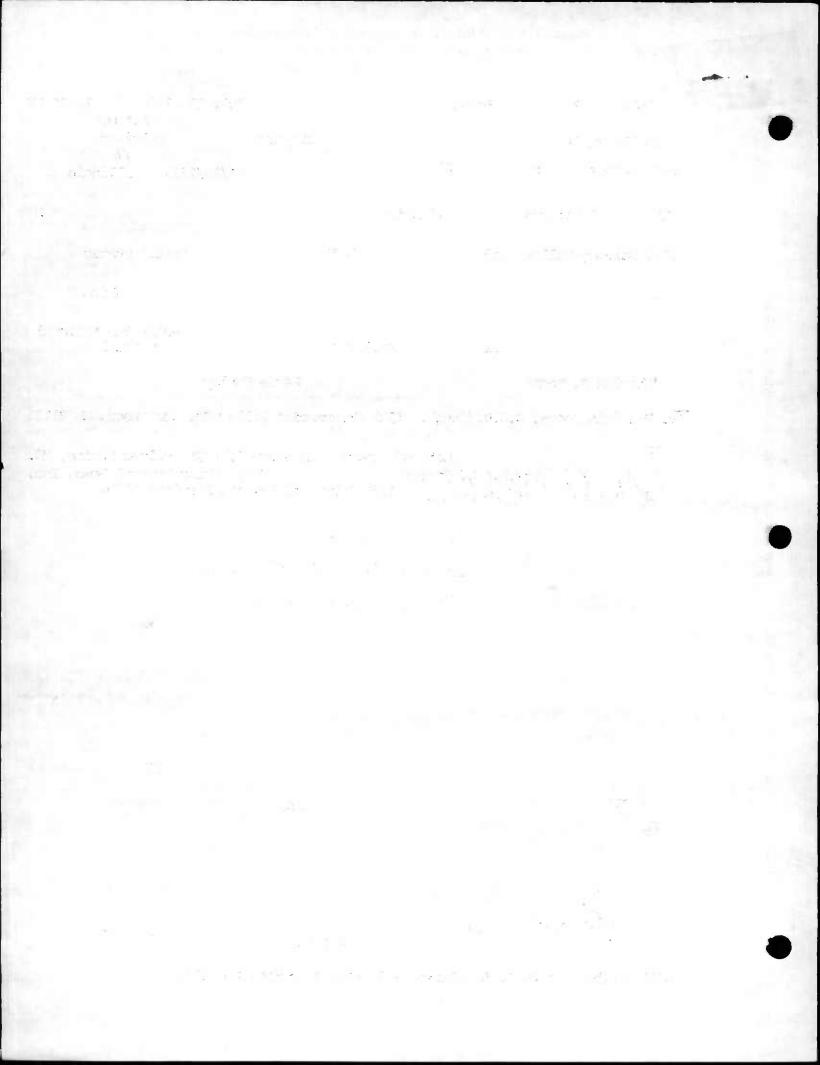
26. Place of Death (Check only one)

Other: Hursing Home 5 | Residence 6 | Other (Specify)

28d. Describe how tnjury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vеа MCLAIN DENNIS **Physician** ENUIS 1639 JUIN 26 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Henrial Hospital Examiner BALTIMORE NION If Under 1 Year If Under 24 Hrs. 9. Birthplace (Stata or Foraign 7. Age (In yrs. last birthday) **Funeral** Days Hours 220-64-9382 M 20 F HULLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No BAIHHK Director Marylos 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 2854 OAKley USA 21215 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Never Married 2 Married 1 Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced er then "neture". the Medical 3 16a. Decadent's Usual Occupation
(Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada complated) Private Business Elementary/Secondary (0-12) nd Mental Hygiene, marked other than umatic event, the Me Coilege (1-4or 5+) ABOTEV 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Be Pages 1 and 2 should be front of Health and Mental? MAKY L. HArris BHARLES MCLAIN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 2726 Forwick AUE Boltimine, Mary (ASD BREWBA 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 110movine boroce 22, Name and Address of Facility Clayuan - Homs 5240 Perstension has BAHINGE, New 21245 21. Signature of Funeral Service Vice 23a. Part1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feliure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical HEMOPTYSIS 12 hours Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury Due to (or as a consequenca of) that initiated events resulting in death) Last Due to (or as a consequence of): signed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown AIDS 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy ils certificate hes t director, pege 2 s 1 Yes 2 No 2 No 1 Tyes Division of Vital apital or Attending Physician: durs after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Spacify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after dea Funeral Diractor 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Sertifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 To the comple 29b. Signal and title of Certifier 29d. Date signed (Month, Day, Year) 29c. License number

ed cause of death (Item 23a) (Type, Print)

strair's Signature

elia Davidson

NOIN

MEMORIAL HOSPITAL, BALTO MD 21218

Registrar

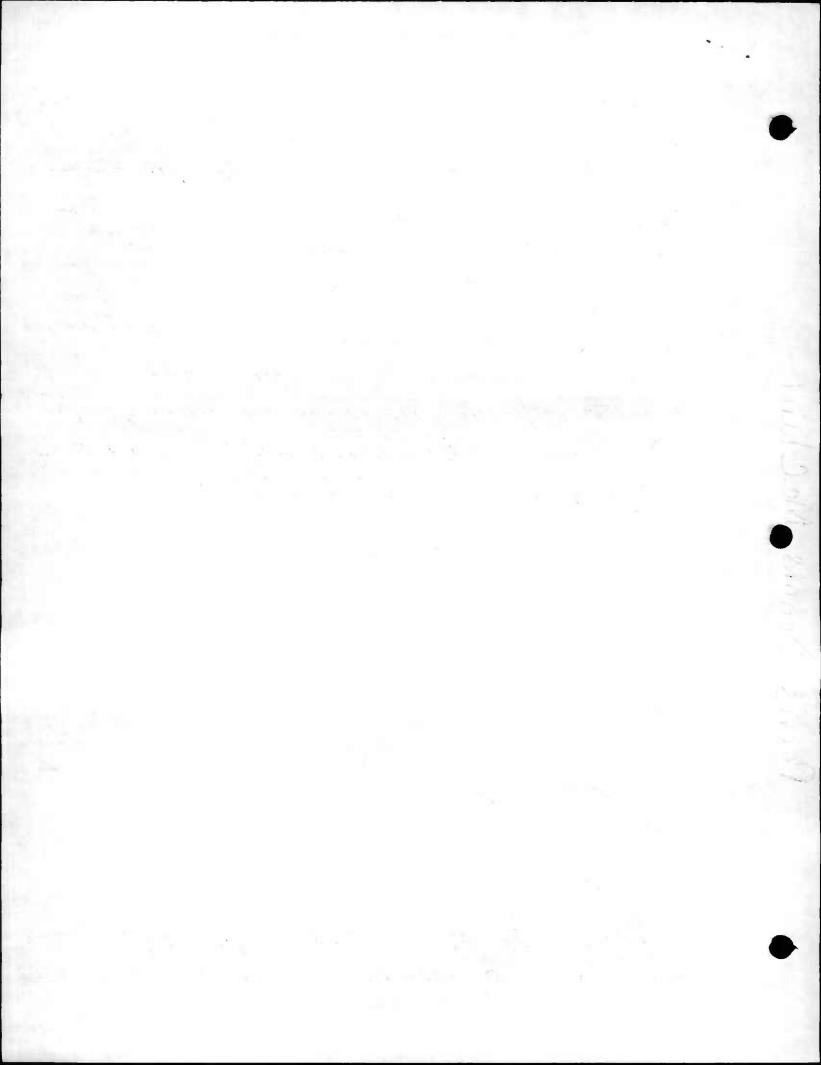
State

30. Name end andress of person who comple

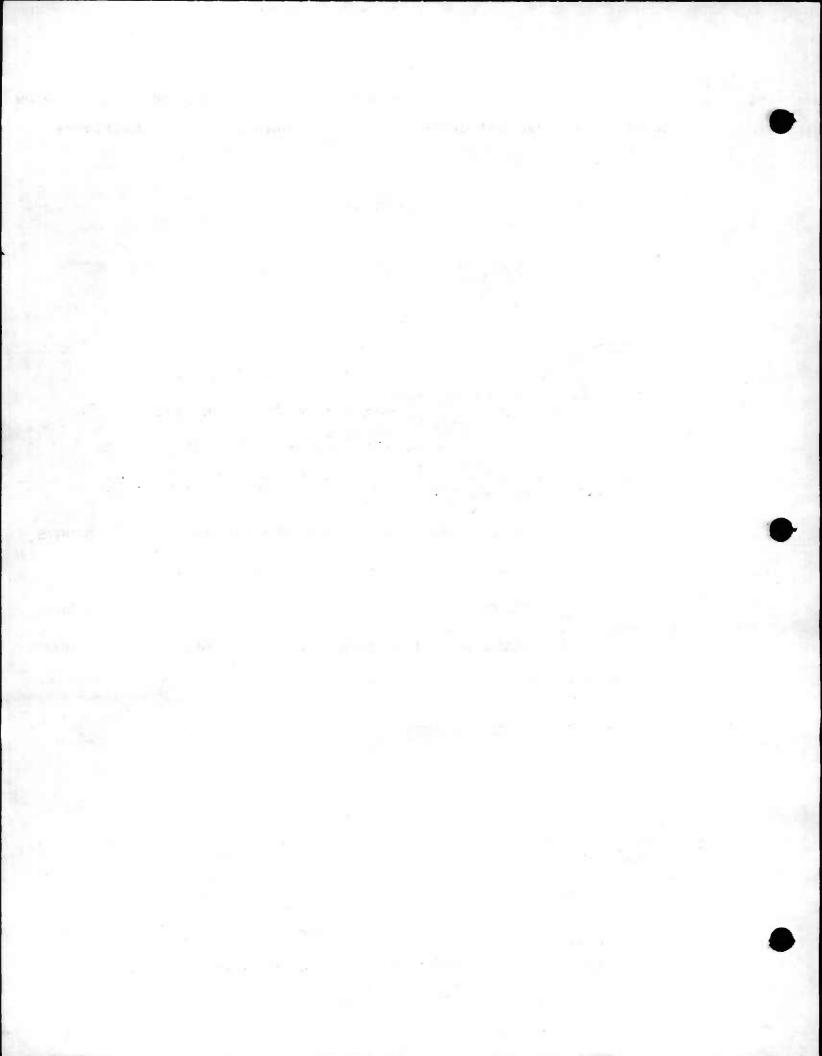
31. Date filed (Month, Day, Year)

AUG

SOMMERVILLE



S. Social Security Number 369-72-7580 1 May Set 7. Age (in yrs. last brinday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Dayly Year) 9. Bird (Month), Dayly Year) 100 Set 1	th timore timore timplece (State or Foreign ountry) tion, OH 10d. inside City Limits 1 Yes XIXNo tountry? ates erican Indien, ia, etc. White			
Funeral Director Social Security Number S	timore timore timplece (State or Foreign puntry) 10d. Inside City Limits 1 Yes XIXNo puntry? ates prican Indien, a, etc. White			
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Specify only ingress grade completed Spec	erican Indien, la, etc. White			
Specify only ingress grade completed Spec				
17. Fethar's Neme (First, Middle, Last) Frank M. Gibson 19e. Informent's Neme/Feletionship (Type, Print) Keith T. Murphy / Son 20e. Method of Disposition MXBuriel 2 Cremetion 3 Cremetor Screen of Screen o	10me			
20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or cametery, cremetory or other place) 20c. Method of Disposition (Neme of cametery, cremetory or other place) 20c. Date 20c. Location - City or cametery, cremetory or other place) 20c. Place of Disposition (Neme of cametery) August 3, 1998 West Bloomfiel 20c. Date 20c. Location - City or cametery, cremetory or other place) 20c. Place of Disposition (Neme of cametery) August 3, 1998 West Bloomfiel 20c. Location - City or cametery, cremetory or other place) 21. Signature of Funeral Home, Inc. 22. Neme end Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Mai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, ACUTE EMBOLIC RIGHT CEREBROVASCULAR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, ACUTE EMBOLIC RIGHT CEREBROVASCULAR 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, ACUTE EMBOLIC RIGHT CEREBROVASCULAR 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, 25a. Due to (or es a consequence of): 25a. Due to (or es a consequence of): 25c. Due to (or es a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c. Due to (or as a consequence of): 25c.				
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Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner ACUTE EMBOLIC RIGHT CEREBROVASCULAR Due to (or es e consequence of): ACCIDENT WITH LEFT DENSE HEMIPLEGIA Due to (or es a consequence of): SEPSIS C. Due to (or as a consequence of): ACUTE ARTERIAL EMBOLIS & RIGHT LOWER EXTREMITY Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribution				
Physician /Medical Examiner Jeg 19	cyland 21230			
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ACUTE ARTERIAL EMBOLIS & RIGHT LOWER d. EXTREMITY Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute	4 DAYS			
Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute				
	robably 4 Unknown			
CHRONIC ATRIAL FIBRILLATION 24e. Wes en eutopsy performed?	Were autopsy findings available prior to completion of cause of deeth?			
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1 2 2 2	city)			
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(eballos, m. D. Desallos, July . 30				
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) LILIA CEBALLOS, M. D., 7620 YORK ROAD TOWSON, MARYLAND 21204	th, Dey, Year)			



Jeran

		. Decedant's Nama (First, Middle			N. H						2. Data of De		Year		of Death
Physician Medical/		Jerome A. McLec							- O'r T-		July		1998)6 A.M.
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M H	-	Sual Rasidance of Decedant Oa. Stata 10b. County			10c. Cit	y, Town or Lo	ocation							10d. Inside	City Limits
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Dire		0e. Street end Number 2113 Crimer R	5eo				10f. Zip		1207		-		Citizen of What Country? USA		
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oleal E		15. Decedent' (Specify only highas)	's Education	Yeer or Datas: ducation de completad) 16a. [ecedent's Usual Occupation siva kind of work dona during most of working fa. DO NOT use retired)					Businass/I		
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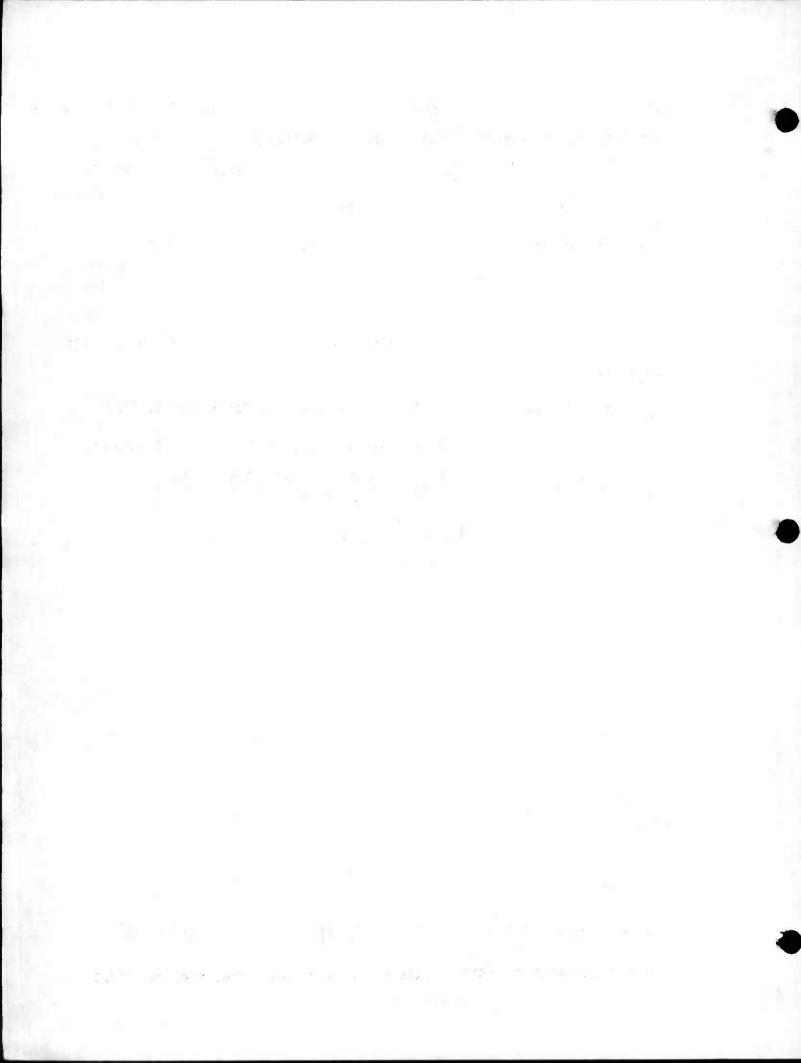
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State of Maryland / Department of Health and Mental Hygiene 23482 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** MACKESSY /Medical 1998 6:20 PM 4b. City, Town, or Location of Daath 4a. Facility Nama (If not institution, giva straat and number) 4c. County of Daath Examiner RIVERVIEW NURSING CENTRE, INCORPORATED BALTIMORE BALTIMORE If Undar Months If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Funeral 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) Days 1 M 2 XF 212-01-2291 81 Director Dec.5 1916 Maryland Usual Rasidance of Dacedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits than "natural", or items 23a or 28a-f shore the Medical Examiner must be notified at Essex Md Baltimore Director 1 ☐ Yas 2 No 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 21221 24 Glenwood Road USA Funeral 11. Marital Status 12. Was Dacedant Evar In U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours aftar 1 □ Navar Marriad 2 □ Married 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 21215-0020 White 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3 Widowed 4 □ Divorced Completed Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) Secretary Glenn L. MArtin 12th Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other treumatic event once. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Helen Lamont Anthony Jankunas 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 1311 Old Eastern Ave. Baltimore Md. 21221 MAry R. Hock/sister-in-law 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cametary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Buriai 2 🖾 Cramation 3 ☐ Ramoval from Stata 8/3/98 Metro Crematory Inc. Baltimore MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licansea 22. Nama and Addrass of Facility
Connelly Funeral Home of essex 300 Mace Ave. Baltimore Md. 21221 ations that caused the death. Depot enter the mode of dylng, such as cardiac or respiratory arrest, la cause on each line. art1. Entar tha disaasa, or complication hock, or haart failura. List only on Approximata Intarval Batween Onsat and Daath Physician /Medical immediata Causa (Final disaasa or condition rasulting in death) 123 Examiner Dua to (or as a consaquanca of): Examiner spital or Attanding Physician: The law requires that the death certificate be exacuted ours after death.

versal Elector: After this certificate has been signed by the attending physician and filled in by the funearel director, page 2 should be detached for use as the burnel-fransit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that in initiated avants rasuiting in daath) Last Dua to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 2 ☐ No encerta Division of Vital Records, 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformad? complation of ceusa of death? 2 000 1 ☐ Yas 1 ☐ Yas 2 ☐ No Be 25. Was cesa rafarrad to medical axaminar? 26. Piaca of Daath (Check only ona) Hospital: Certification: To 1 Yas 2 No Other: 4 Uursing Homa 5 Rasidanca 6 Other (Spacify) 1 Inpatlant 2 ER/Outpatiant 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturai 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 4 Homicida 24 hours a Cartifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Medical 29a. Cartifian To the Hosp within 24 hor To the Fune completely fi (Check only Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) mark 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) MICHAEL SCHWARTZ MD 5517-A Ritchie Highway, Baltimore, Maryland 21225 31. Data filad (Month, Pay Year)

Registrar's Signature

State Registrar

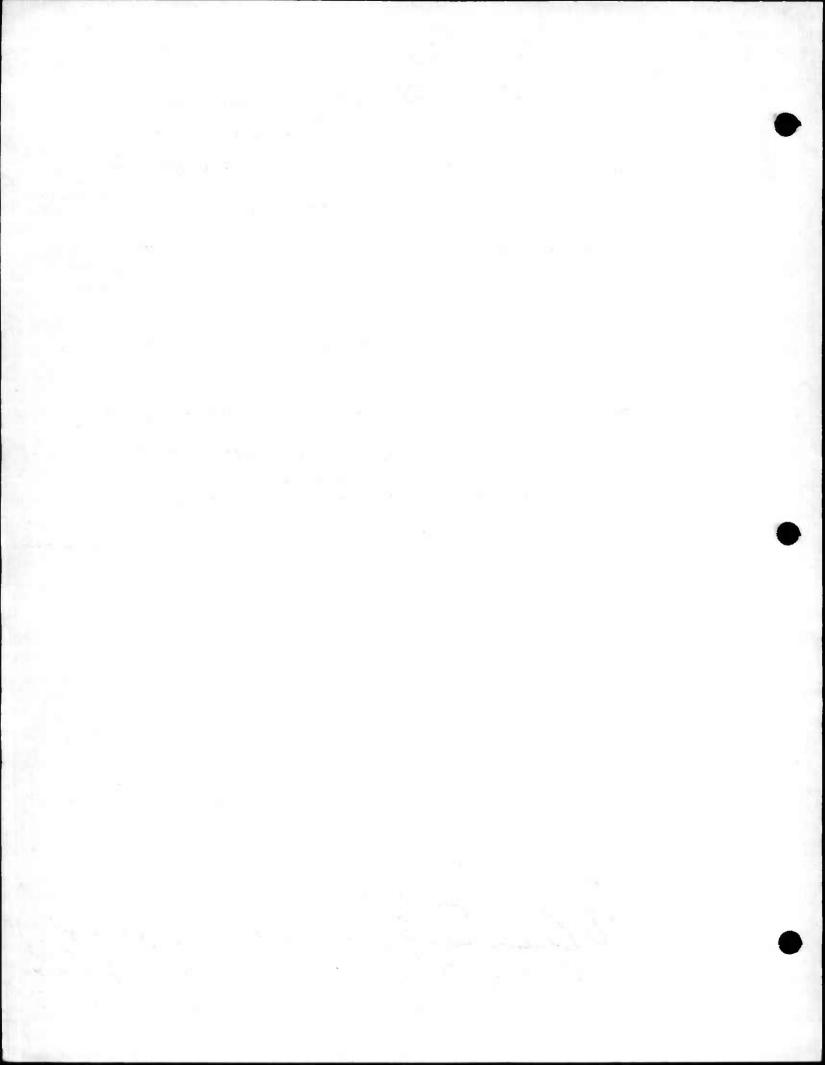


State of Maryland / Department of Health and Mental Hygiene

Item#26 perPhy G762 8/3/98 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** THOMAS LEE MILLER JULY 1998 25 7:55am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 9321 Snyder Lane Perry Hall Baltimore If Under 24 Hrs. Hours Min. 5. Sociei Security Number if Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Months 1♥ M 2□ F Yrs 216-20-9789 Director May 28 1927 Maryland Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-1 show traumetic event, the Medical Examiner must be notified at Baltimore Md. Middle River 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 7304 Greenbank Road 21220 USA death Funeral permit Peges 1 and 2 should be filed within 72 hours effer dear Department of Health end Mentel Hygiene. Important: If Item 27 is marked other the any injury or other trauments. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic OrlgIn? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ✓ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2√ Married 1 Yes 2 No Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Electrician General Motors 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Miller Margaret Ruckle 2 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredericka Miller / wife 7304 Greenbank Road BAltimore MD. 21220 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery 7/29/98 Baltimore Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home of Essex Do not enter the mage with year as Ball timere MD. 21221 Approximate Interval Between Onset and Deatl Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner **burial-tran** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and ed by the attending physician deteched for use as the buria P.O. Box 68760. 8 cian/Medical that initiated events resulting in death) Last Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? Physi 10 768 2 No 3 Probably 4 Unknown ate hes been signed page 2 should be det þ 24b. Were autopsy tindings evelleble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? certificate hes 1 ☐ Yes 21 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 3 Residence 8 Other (Specify) Residence 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth spital or Attanding P.
nours effer death.
neral Director: Affer t 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours ef To the Funeral DI completely filled in 1 Certifying Phyefclan: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Exeminer: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2733 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 7620 YINK Rd TOWSON, MD 21204 rahi 32. Registar's Signature 31. Dete filed (Month, Day, Year) State Julia Davidson-Randelle AUG Registrar

DHMH 16 Rev 6/95



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WR.	Certificate of Death	Reg No		~ 0 4 (14

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T.			Decedent's Neme (First, Middle, Last)											2. Dete of Dea		Veer	3. Tim	e of Death
н	Physicia	_	DARRE	LL GI	EN	N McN	AT	Г						JULY	Day 28,	1998	063	25 AM
1	/Medica Examine	_	4a Fecility Nama ((If not institutio	n, give	street end n	um <i>ber)</i>						4b. City, Town, or L	ocation of Deeth	4c. Cour	nty of Deeth		
			1715 EAR	HART R	OAD								DUNDALK	Baltimore				
	Funeral Director		220-82-3920							r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yaer) June 10,1964		Birthplace (State or Foreign Country) MAryland				
	within 72 hours effer death with the Maryland ene. than "satural", or items 23s or 28s-f show he Med cal Examiner must be notified at ampleted by Funeral Director	-	Usual Residence of Dacadant 10a. State 10b. County 10c. City, Town or Location									Od Insid	e City Limits					
		ctor	Md.	Balt		re		100.0	Middle Rive							10	Yes 2X No	
	# 22 #													1	0g. Citizen o		ntry?	
	23a		7410 (Gunpowe	ler	Road						-	21220		USA			
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Important: If Items 23a or 28a-1 show important: If Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Example of multiple and page.	by Funeral	11. Marital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced			1 Yes 2 No			Vas Dece Yes, spe		dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, Whita, cify: W		٦,		
ŏ	2 hou	0		15. Deceder	nt's Edu	cation			16a.	Deced	ent's Usu	al Occup	pation		16b. Kind of	Business/In	dustry	
Maryland 21215-0020	within 72 ene. than "n	Completed	(Specify only highest gred Elamantary/Secondary (0-12)			completed College		5+)			ROOF		pation during most of word d)	king	Roo	fing		
P	ntel Hygie od other event, tr	Ö	12th 17. Fether's Name	(First, Middle,	Last)								18. Mother's Nan	ne (First, Middle,				
lan	ld be entel ked c	lo Be	Fai	rl McNa	1+								Hele	en Bassi	inger			
ary	should ind Men i marke umatic	-	19e. Informent's N			rpe, Print)			19b	. Mallin	g Addres	s (Street	end Number or Ru			wn, Stete, Zij	Code)	
	end 2 seath an n 27 is	-	Terry B	utterwo	orth				4	819	9 HAzelwood Ave. Baltimore Md. 21206							
ē,	f Head	ŀ	20a. Method of Dis	sposition				20b.	Place of	Dispos	sition (Na	me of	(0)	Data	20c. Locetic	on - City or T	own, Stat	е
9	Pages nent of nrt: If its iry or o		1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)											/31/98	Balti	more	Md.	
Baltimore,	Departi Departi Imports any inje	=	21. Signature of Fi	Tira	M	(0)	Callego	lle	1 801	3	onne 00 M	lly Ace	Funeral I Ave. Balt	timore M	D.2122	21	Approx	imate
	Physician /Medical		shock, or hea	•	0000	na causa on							ng, such as cardied	or respiratory of			Interval	Between end Daath
	Examiner		disease or condition resulting in deeth)	on		e. Due to (or as a consequence of):												
Τ	uted Insit	Examiner				b		Due to /										
90,	cate be executed physician and the bunal-transit	Exa	Causa (Disease or Injury															
68760,	- 01	Medical	that Initiated events rasulting in death) Last Due to (or as a consequence of):															
Box	eath certific attending p	and				d										1		
	dea be att	200	Part II. Other signi	ficant conditi	ons co	ntributing to	death b	ut not re	sulting in	the ur	ndartying	ceuse gi	ven in Pert I.	23b. Dld t	obacco uae	contribute t	o the cau	use of death?
, P.O	₹ 90	by Physician/M												1 🗆 1	'es 25 N	o 3 Pro	bably	4 Unknown
Records	O 8 2 2	Completed												24a. Was a	an autopsy mad?	av	ailabla p	psy findings rior to n of ceusa
	The law ate hes page 2	0												18 Y	es 2 No	1	Yes	2 No
Vital	ician: The	D P	25. Was cese refe	rred to medice	1								26. Pleca of Dea	ath (Check only o	ne)			
	0 0 Z	0	examiner? 1 ∑ Yes 2 □] No	1	Hospital: 1] Inpatie	ent 2	ER/Ou	tpetien	3 D	OA Ot	her: 4 🗆 Nursing H	lome 5 🗆 Resid	ence 6 🗆	Other (Speci	(y)	
ion of	Attanding Ph r death. octor: After th by the funeral		27. Manner of Dee 1 Natural 2 Accident	5 Pendi	ng igation	28a. Date (Mo FOUND	nth, De	y Year)		Time of njury ID 6:	004	28c. Inju Wo 1	ryat rk? ∣Yes 2.1 X INo	28d. Describe h	ow Injury oc	curred		
Division	Hospital or Attanding 124 hours after death. Funeral Director: After etely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🖾 Could determ			e of Inj	c. (Speci	nome, fa	rm, stre	et, factor	ry, offica		28f. Location (S City or Tow DUNDALK	n, Stete)]	715 EAR	e/ Route HART	Number, ROAD,
		dicai	29a. Certifier (Check only one)	1□ Certifyin	ng Phy Exami	aiclen: To the ner: On the and ma	basis o	examin	owledga ation an	, daath d/or inv	occurrad	at the ti	ma, data and plece opinion, daeth occu	, end due to the d	ause(s) and	menner es	stated. o the cau	ise(s)

29b. Signature end title of certifier

29c. Licensa number

29d. Date signed (Month, Day, Year)

OCME

JULY 28, 1998

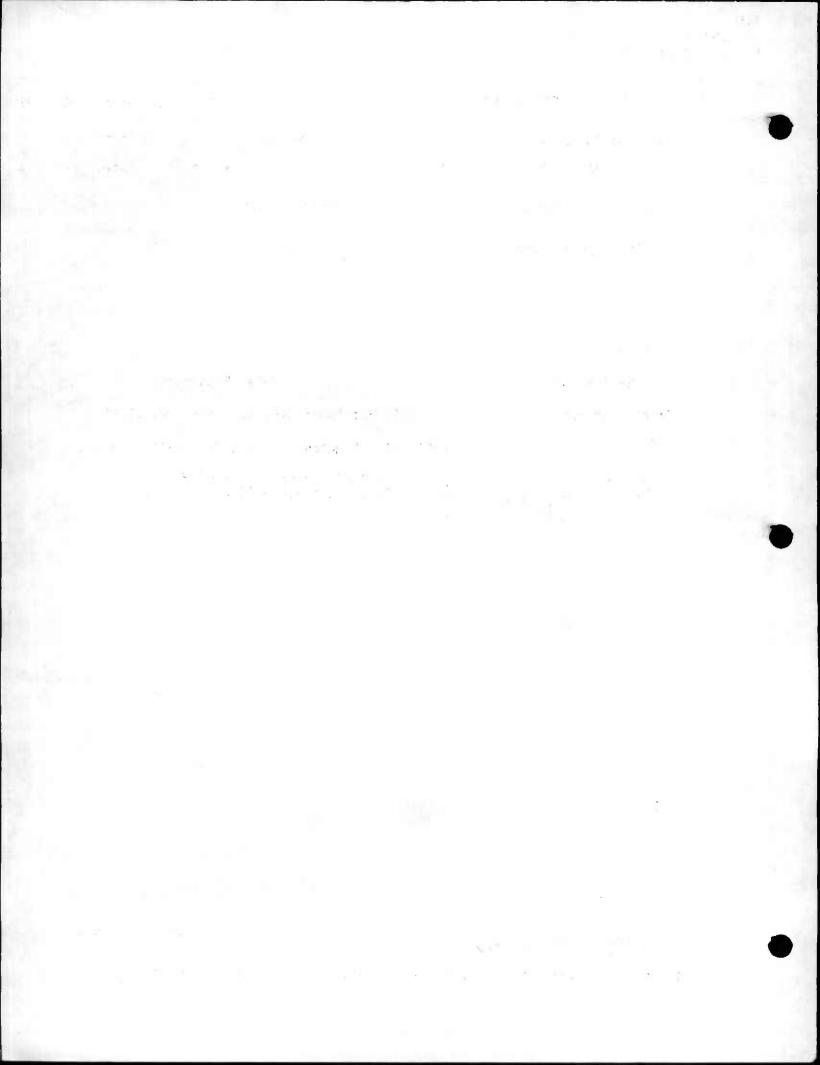
30. Nema end eddress of person who completed cause of death (Itam 23a) (Type, Print)

Margarita Korell M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

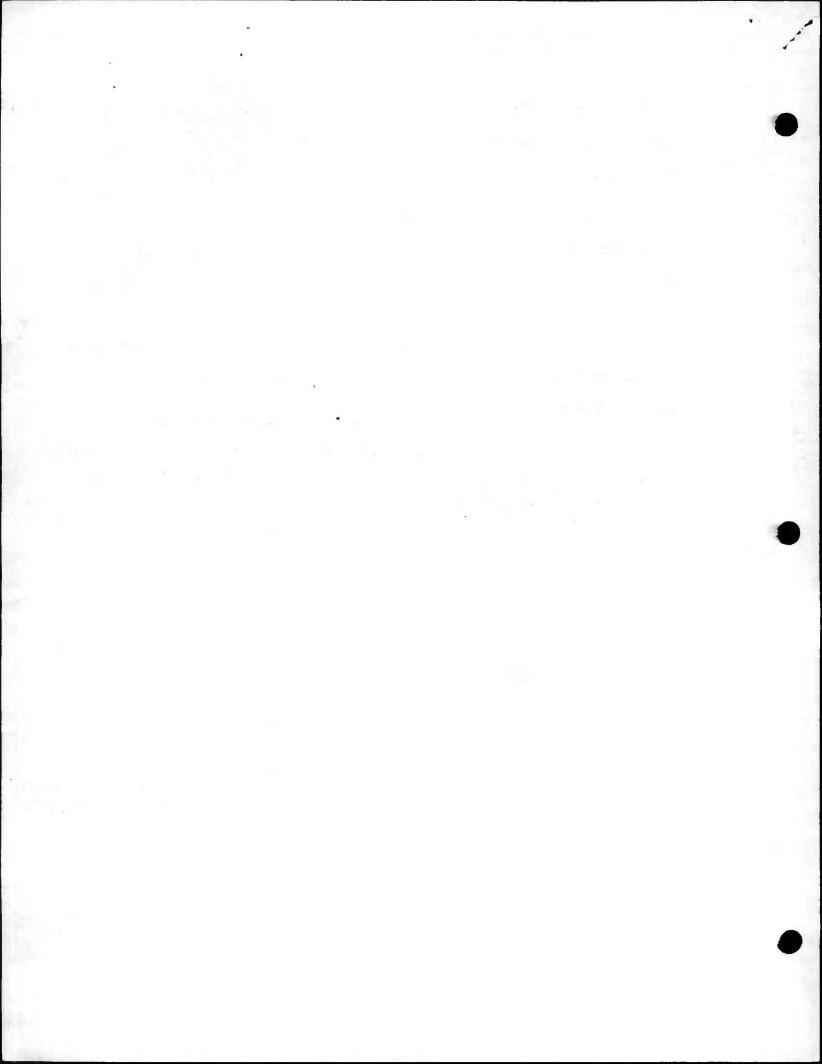
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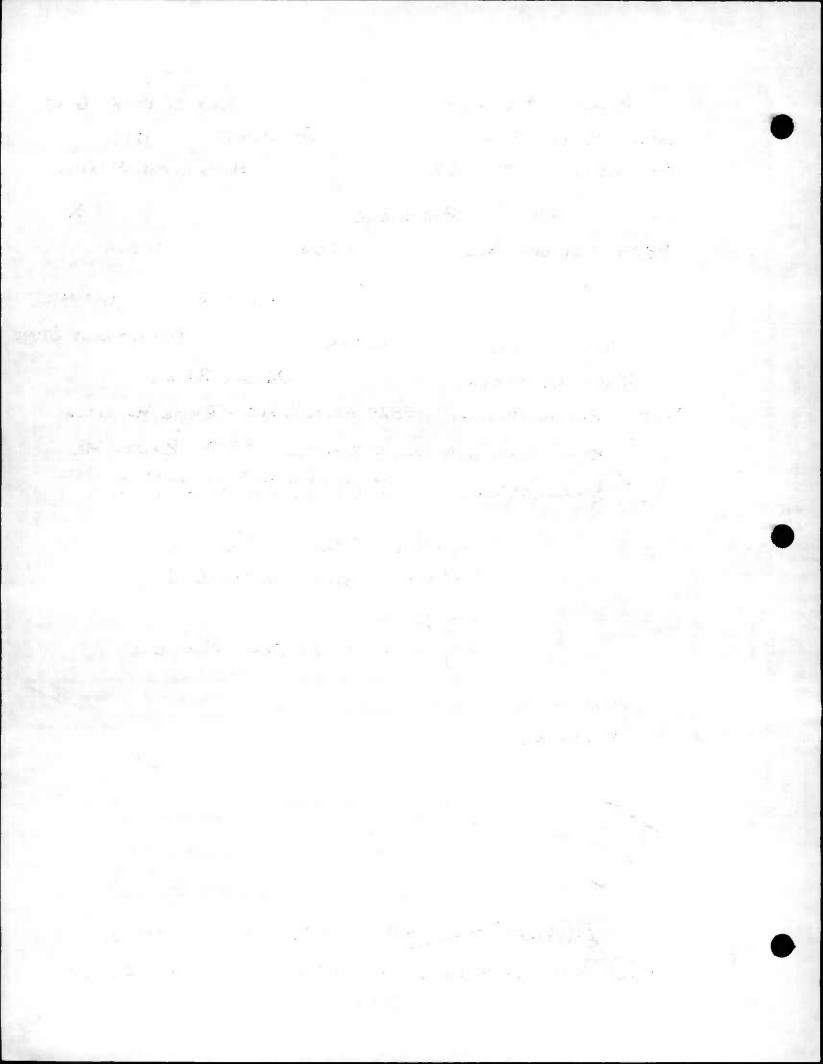
				Please	Type or Pri State of M		d / Depa		Health and I		_	0 0	3485	
	Physici /Medic		Franc	me (First, Middle, La Ces R. Ma	cciola					2. Dete of De Month	Dey 29	1998	3. Time of Death 7:36 An	
<i>}</i>	Examir Funeral Director	ner	4e. Fecility Neme (If not institution, give street end number) Stella Maris at Mercy Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1 M 2 F 88 Yrs. Wonths Usuel Hesidence of Decedent						Baltimore Trunder 24 Hrs. Hours Min.		rth ey, Year)		ce (State or Foreign y) ersey	
	death with the Maryland ims 23e or 28e-f show if must be mutified at	tor	Usual Hésidence of Decedent 10e. State 10b. County 10c. City, Town or Local MD N/A Baltimore									100	d. Inside City Limits	
:		ral Director	10e. Street end N 4902 R					10f. Zip Code 2121			10g. Citizen of U.S.			
	or he	by Funeral		rried 2 Married	12. Wes Decedent Armed Forces 1 Yes 2 H If Yes, Give Yeer or Detes:	? INo		/es Decedent of Yes, specify Cul ☐ Yes 2 No	Hispenic Orlgin? (S pan, Mexicen, Puert Specify:	pecify Yes or No o Ricen, etc.)		ce - Americar ck, White, et b: White	c.	
7200-612		leted	(Sp	15. Decedent's E ecify only highest gr			16e. Decede	ent's Usuel Occur ind of work done	pation during most of wor	king	16b. Kind of B	usiness/Indu	stry	
within iana.	Be Completed		e (First, Middle, Last		5+)	Super		18. Mothar's Nan	na (First, Middle			hers		
Maryia	permit. Paggas i and z should be lied Department of Health and Mentiel Hyg Important: if item 27 is marked other any injury or other traumetic event, once.	То	19e. Informant's I	Macciola Name/Reletionship (Type, Print)				Sarah Sarah		per, City or Town		ode)	
partituore,	ragas i ar mant of Haa ant: If Item; ury or otha		1 Structure Compation Compation Compation Compation Compation or other piece)									n - City or Town, Stete		
Dail	Departi Departi Importa any inj		21. Signeture of Funeral Service Licensea 22. Nama and Address of Fecility Dippel Funeral Home Inc. 23e. Pert1. Enter the disease, of complications the caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, Intervel Between											
	Physician /Medical Examiner		Immediate Ceuse disease or condit resulting in death	e (Finel	e. Cano	ur	of es e consequ	the 1	pituitary				Onset end Deeth	
x 00/00,	ding physician and	Medical Examine	Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or es e consequence of):											
	e atter	Physician/M	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.						iven in Pert I.	23b. Did tobacco use contributa to the causa of d				
cords, P.	lew requires mat me as been signed by th a 2 should be datache	by	Color	ng c	Cencer						Yes 2□ No sen autopsy	24b. Were	bly 4 Unknown a outopsy findings	
Leco	a has beer aga 2 shou	Completed		ng c	ancer						ormed?	of de	eble prior to plation of cause ath?	
DIVISION OF VITAL	iding Physi th. After this o	Certification: To Be	25. Wes case referexaminer? 1 Yes 2 2 2 3 2 3 4 2 4 2 4 2 4 4 4 4 4 2 2 4 2 2 4 2 2 4 2 2 4 2	ath 5 Pending invastigalio 6 Could not b determined	e 28e. Place of In building, e	njury - At hor	City or Town, Stata)							
	within 24 h To the Fur	Medical	(Check only one) 29b. Signetura an	2 Medicat Exar	niner: On the basis of end menner s	of examinati teted.	on end/or inve	estigetion, In my	opinion, deeth occu	rred et the time,	dete end plece,	end due to to	he ceuse(s)	
	4		30. Nama and add	drass of person who	completed cause of	deeth (Item	23a) (Type, P	Print) 767	D40480 2 3elai 1 to , M	- RA	July 36	301		
	Sta Registr	-	31. Deta filed (Mo			rar's Signat			., .,					



State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth 6:05 AM Dey **Physician** 31, 1998 ANNA E. MEEKINS JULY /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner BALTIMORE ALM LORIEN NURSING CENTER-If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthpleca (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Deys Months MEXICO Yrs. 87 453-07-1049 MARCH 11-1911 Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event. 10a. Stete 10b. County 10c. City, Town or Location 10d. Ineide City Limits 1 Yas 2 □ No MD Director BALTIMORE 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5825 AVE 21206 U.S. A ARIZONA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married 1 Nes 2□ No Specify: HISPANIC þ MEXICAN 3 Widowed 4 Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) DEPARTMENT STORE College (1-4or 5+) CLERK AIN 17. Father's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumema) Be REZA MARIA ZACARIAS EVORA 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 5825 ARIZONA AVE. - BALTO, MD. 21206 AUGUST F. MEEKINS-HUSBAND 20b. Pleca of Disposition (Nema of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 8-3-98 BALTO, MD. GARDENS OF FAITH CEM. 4 □ Donetion 5 BOther (Specify) ENTOW BNENT 21. Signature of Eugeral Service Licenses 22. Nema and Address of Fecility HARTLEY MILLER FUNERAL HOME - CHTD. 7527 HARFORD RD. - BALTO, Mr. 21234 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner to (or es e consequence of): Examiner Cercoro vasantas Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in death) Last Due to (or es e consequenca of): Due to (organ a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical The law requires that the death certificate to vas inlar disease 1 Knopher 23b. Did tobacco use contribute to the cause of death? signed by the a Pert If. Other signiffcent conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 thknown 1 Yes 2 No P 24b. Were eutopsy findings eveileble prior to completion of cause of death? should 24a. Was an autopsy Completed s certificate has t 1 Yes AUNO 1 ☐ Yes 2 ☐ No After this certifical funeral director, or Attending Physician: after death. 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Panding Investigation 1 Yes 2 No 2 Accident Director: / 6 Could not be determined n 24 hours after de re Funeral Directo pletely filled in by th 3 Suicida 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Placa of Injury - Af home, farm, street, factory, office building, etc. (Specify) 4 Homicide Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. edicai 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 29c. Licansa number 29d. Dete signed (Month, Day, Year) 2 MD D3146 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) BACK RIVER NECK RID MI BALTIMORE 201-109 31. Date filed (Month, Day, Year) relia Davidson-Randell

Registrar DHMH 16 Rev 6/95

1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** OZQZEWSKi JUIV 1998 athenne *a*8 /Medical 4a Fecility Neme (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner MD Howard HOSPITAL Columbia Howard County General 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthpiece (State or Foreign Country) 5. Social Security Number **Funeral** Months Deys Hours 1 M 2 F 96 Yrs. 212-03-7123 Director 10/5/1901 **MARYLAND** Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD HOWARD ELLICOTT CITY 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with 3004 N. RIDGE ROAD 21043 U.S.A. death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 12 ACCOUNTING CLERK A & P TEA COMPANY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be to Department of Haalth and Menial Important: If Item 27 is marked of any Injury or other traumatic eve CONSTANTINE M. TURNER MARY (WADE) 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ANNETTE SANDERS (SECOND COUSIN) 205 DEVON COURT LINTHICUM, MD 21090 altimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Burlal 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) HOLY ROSARY CEMETERY 8/1/98 BALTIMORE, MD 22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 21. Signeture of Funeral Service Licenses 1630 EDMONDSON AVE CATONSVILLE, MD 21228 remner 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) **Examiner** CHROWIC AUTIGOAGUL Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): and HROWIC ATRIAL physician Box 68760 Physician/Medical Due to (or es e consequence of) the 88 attending for usa as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Unknown ð Records, 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? should 24e. Wes en eutopsy Completed has page 1 Yes 2 No 1 Yes 2 PNo certificate of Vital Physicien: diractor 25. Was case referred to medical Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After this funeral o 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: Division or Attending 5 Pending investigation To the Hospital or marking within 24 hours after Best To the Funeral Director Aft 1 Waturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. edicai 29a, Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier Michael Musor wel 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 11085 CITTLE PATUXELST PERSY \$100 COCUMBIA MODOW MADON M.D. 32. Registrar's Signeture .

DHMH 16 Rev 6/95

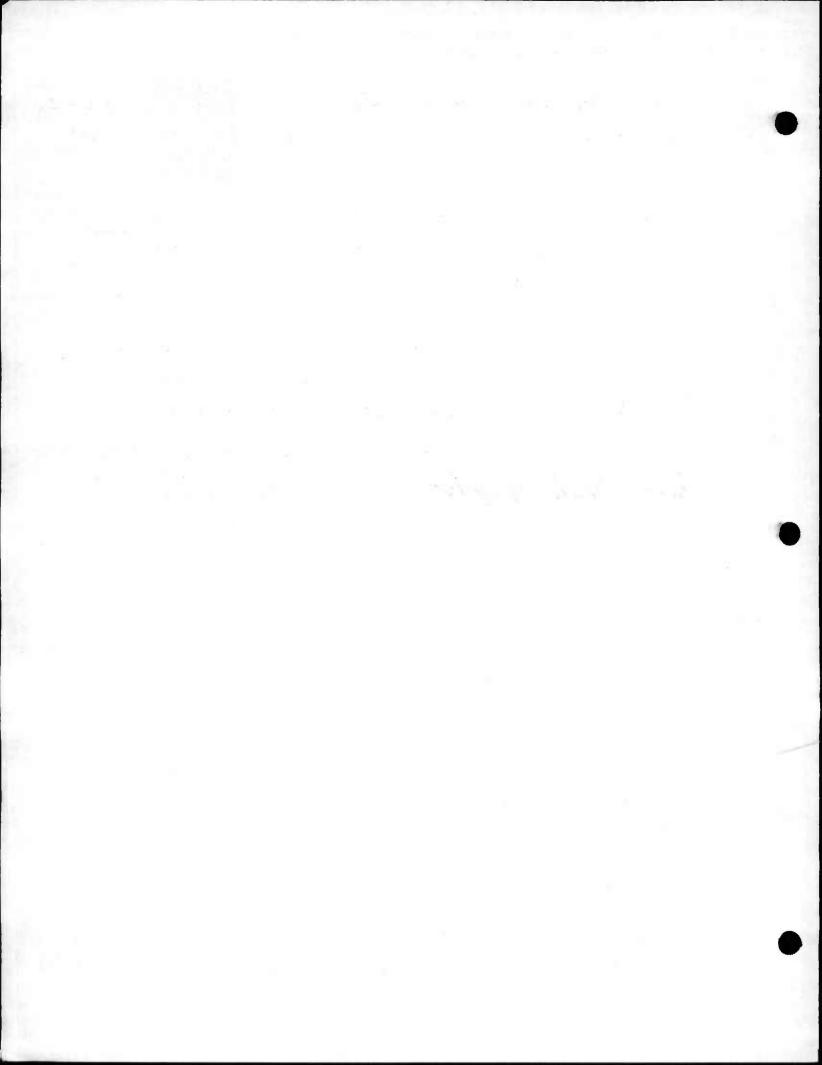
State Registrar

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	1 December 1 Nome / Class 1 Middle	14)		Certifica	te or	Death			eg. No.			
cian	1. Decedent's Name (First, Middla, I		DOON	nor Ji	,			Date of Deat Month	Dey	Year	3. Time of Death	
lical	John Jose 4a. Facility Name (If not Institution, g		OCON	NOV 2		4b. City, Tow		ugust	4c. County	1998	03:20	
iner	Johns Hopking		. DAsdi	10/10/10		Balti			, , , , , , , , , , , , , , , , , , , ,	amo	VP.	
1		5. Sex 7. Ag	e (In yrs. last b	irthday) If Unde	r 1 Year	If Under 2	4 Hrs. 8.	Date of Birth		_		
r	212-12-5432	XXM 2□ F 8	5	Yrs. Months	Days	Hours	Min.	Date of Birth (Month, Day, BYCI)	1913	Maryl	ace (Stata or Foraign lry) and	
	Usual Residence of Decedent 10a. State 10b. County		100 Chr. Tor	um ou l'acation								
5				wn or Location						10	od. Inside City Limits 1 ☐ Yes 2 ☐ No	
ect	Maryland Baltime	ore	Baltin		p Code			1	0g. Citizen of	What Count	1 Yes 2 No	
Ö	8820 Walther Blv	d # 2508			234			,	USA	WHO COUNT	, y 1	
Funeral Directo	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Dece		lispanic Origi	n? (Specify	y Yes or No-	14. Rac	e - America		
	1 ☐ Never Married XX Married	Armed Forces? 1) XYes 2 ☐ I If Yes, Give	NO WWII	1 ☐ Yes		an, Mexican, Specify:	Puerto Ric	an, etc.)		Black, White, etc.		
d by	3 Widowed 4 Divorced	Year or Dates:		1 163	4t-Aivo	эреспу.			Specify	v: Whi	te	
lete	15. Decedent's (Specify only highast g	Education grada complated)	16	a. Decedent's Usu (Giva kind of wi life. DO NOT u	al Occup ork done	ation during most o	of working		16b. Kind of B	usiness/Ind	ustry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		isa ratiro	4)			Marait	ima		
Be Co	17. Father's Name (First, Middla, La			Lawyer		18. Molher	s Name (F	irst, Middla, A	Marit Maidan Suman			
ToB	John Joseph O'Cor	nnor							onnelly			
	19a. Informant's Name/Relationship	(Type, Print)		b. Mailing Addres		and Number	or Rural R	outa Number	, City or Town,	Stata, Zip	Coda)	
	Jane Hale O'Con	nor W		320 Walth			2508	Balto	Md 212	234		
	20e. Method of Disposition XX Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place cemet	of Disposition (Na ery, cramatory or	ma of othar plac	ce)		Dale	20c. Location -	City or Tov	wn, State	
	4 □ Donation 5 □ Other (Space		Dulaney	Valley Me	moria	1 Garder	ns 8/	4/98	Lutherv	/ille,	Maryland	
	21 Agnature of Funeral Service Lic	ogue //	1	22. Name e	nd Addre	ss of Facility	Mitc	hell-W	iedefel	d Hom	e Inc.	
	Dennis Dush	on Kena	Per	6500 \	/ l .	D 1 5						
	22a Dartt Enter the discussion of an			0300	ork	Road L	Baltin	more,	Marylar	10 612	14	
_	23a. Part1. Enter the dise of or co shock, or heart failure. List on	omplications that caused bly one cause on each lin	the death. Do	not enter the mo	ONK de of dylr	ROAD L	Baltin ardiac or re	more,	Marylar _{est,}		Approximate Interval Between	
				not enter the mo	OPK de of dylr	ROAG L	Baltin ardiac or re	More, I	Marylar _{est,}		Approximate Interval Between Onset end Death	
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State Registrar

31. Date filed (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygiene 23489 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete oi Deeth 3. Time of Death Month **Physician** PITTMAN MELVIN AUGUST 01 4.40 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County oi Death **Examiner** CHURCH HOSPITAL 7. Age (In yrs. lest birthday) If Under 1 Yeer Months Deys Baltimore N/A Il Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
Oct 3, 1953 5. Sociel Security Number 9. Birthplece (State or Foreign Country)

Md **Funeral** 1 XM 2 □ F 215-60-0161 44 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits must be notified at Md N/A Director 1 X Yes 2 ☐ No Baltimore "natural, or items 234 of 268-10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2431 East Lafayette Avenue 21213 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 蒼 No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Never Married 2 Married 1 Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Induatry $\overset{\text{Elementery/Secondery (0-12)}}{12th}$ College (1-4or 5+) permit. Pages 1 and 2 should be filled in Department of Health and Mertal Hygion Important: If them 27 is marked other the any injury or other traumers Maintenance Janitor 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Jessie Pittman Ruby Hill 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ruby Pittman (Mother) 201 N. Washington St. Apt. 701 Balto 21231 20b. Place of Disposition (Name of cemetery, cremetory or other place)

Mt. Zion Cem 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete Aug 6,1998 Lansdowne, Md. 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name and Address of Fecility Caple Funeral Service 21. Signature of Funeral Service Licenses 5502 Winner Avenue Baltimore, Md 21215 cations thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical HEPATIC FAILURE. DAYS Examiner Due to (or es e consequence oi): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): NEUMONIA Records, P.O. Box 68760, i or Attending Physician: The law requires thet the death certificate i effect death.

Director: After this certificate hes been signed by the ettending physic in by the funeral director, page 2 should be deteched for use as the it thet initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cese referred to medical exeminer? Be 28. Piece oi Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA P 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner stated. Medicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) . P. KURUVILLA, M, J 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) M.D., CNURCH HORPITAL KURUJILLA Registars Signature

Julia Davidson-Randall 31. Dete liled (Month, Dey, Year) 32. Regis ar's Signature Registrar

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State of Maryland / Department of Health and Mental Hygiene 3490 Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month **Physician** George Willard Price 4b. City, Town, or Location of Death 1998 28 22:10 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs. 73 218-18-0972 Director Dec. Usual Residenca of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Marital hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any Injury or other traumatic event, if a Modical Examinat must be notified at 000. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 No Director MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Overbrook Road 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Maritel Status Biack, White, atc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Md. Glass & Mirror Elementary/Secondary (0-12) College (1-4or 5+) 12 salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther Suter James W. Price P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Overbrook Rd., Baltimore, Md. 21228 Margaret Price, sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-1-98 Baltimore, Md. Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228 Lemm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximete tntervat Between Onset and Death **Physician** /Medical tmmediate Ceuse (Finat Atherosclerosis, generalized, marked diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Vegetations, aortic valve months ettending physicien end I for use es the buriai-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last Due to (or es e consequenca of): Bland cerebral infarct with secondary hemorrhage 2davs on of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the e 23b. Did tobacco usa contributa to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. Hemorrhagic cystitis 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy Completed peen: pege 2 1 Yes 2□ No 1 Yes 2 □ No certificate Attending Physician: director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) GEORGE Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 10 this 27. Menner of Deeth 1 Matural 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After 5 Pending ar death. 1 Yes 2 No Investigation 2 Accident S 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) DIVI Et hours after of Funeral Office letely filled in by 4 Homleide 29a. Certifier 11 cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. To the To the To the I 29b. Signature end titte of cartified 29c. License number 29d. Date signed (Month, Day, Year) willow, mis. D08949 July 29, 1998 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Bert F. Morton -St. Agnes HealthCare - 900 Caton Avenue - Baltimore, MD. 21229

State Registrar

31. Date filed (Month, Day, Year) AUG

32. Registrar's Signature riha Davidson-Randese to a second to the second deep will be and the company of the same of

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death MARY Month S. PONIATOWSKI **Physician** 2 JULY /Medical 4e. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** N/A Church Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10 / 22 / 1924 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Months 1 M NE Yrs. Maryland Director 217-12-0607 Usual Rasidanca of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. inslda City Limits Baltimore N/A Maryland XXYes 2 No **Funeral Director** items 23s or 28s-f ner must be notifie 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? death with 21231 USA 2057 Gough Street NAME KNOWN TO PHYSICIAN 12. Was Dacadant Evar in U.S. Armad Forces? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married b Specify: White 1 ☐ Yas XXNo Specify: Completed by ₩Widowed 4 Divorced 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) Pages 1 and 2 styling the freedown timent of Health and Mental Hygier tant: If item 27 is marked other th lury or other traumatic event, the Unknown Homemaker Domestic 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Julian Rzeczkowski Stanislawa Peplowski 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 2057 Gough Street Baltimore, Md. 21231 Stanley J. Poniatowski/ Son Baltimore, 20e. Method of Disposition 20b. Piaca of Disposition (Nama of camatery, cramatory or other placa) 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 17/31/98 Baltimore, Maryland Signature of Funeral Service Mon 22. Name and Addrass of Facility David J. Weber Funeral Home 401 S. Chester St. Baltimore, Maryland 21231 complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximata Interval Between Onsat and Death Part1. Enter the dise **Physician** . Chronic Obstructive Pulmorary Disease Immediata Causa (Final disease or condition resulting in death) /Medical many years Examiner Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-trans Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Causa (Diseese or Injury that initiated avents rasulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760, Dua to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? poly wordism 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Wes an autopsy performed? certificate has 2 No 1 Yas 1 ☐ Yas 2 ☐ No of Vital Attending Physician: Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) all or An.

July altey death.

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" by the funeral dir. 1 Yas 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Deta of Injury (Month, Day Year) 26b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred ision 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 26a. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 4 Homicida To the Hospital o within 24 hours at To the Funeral Di completaly filled is to Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner as stated.

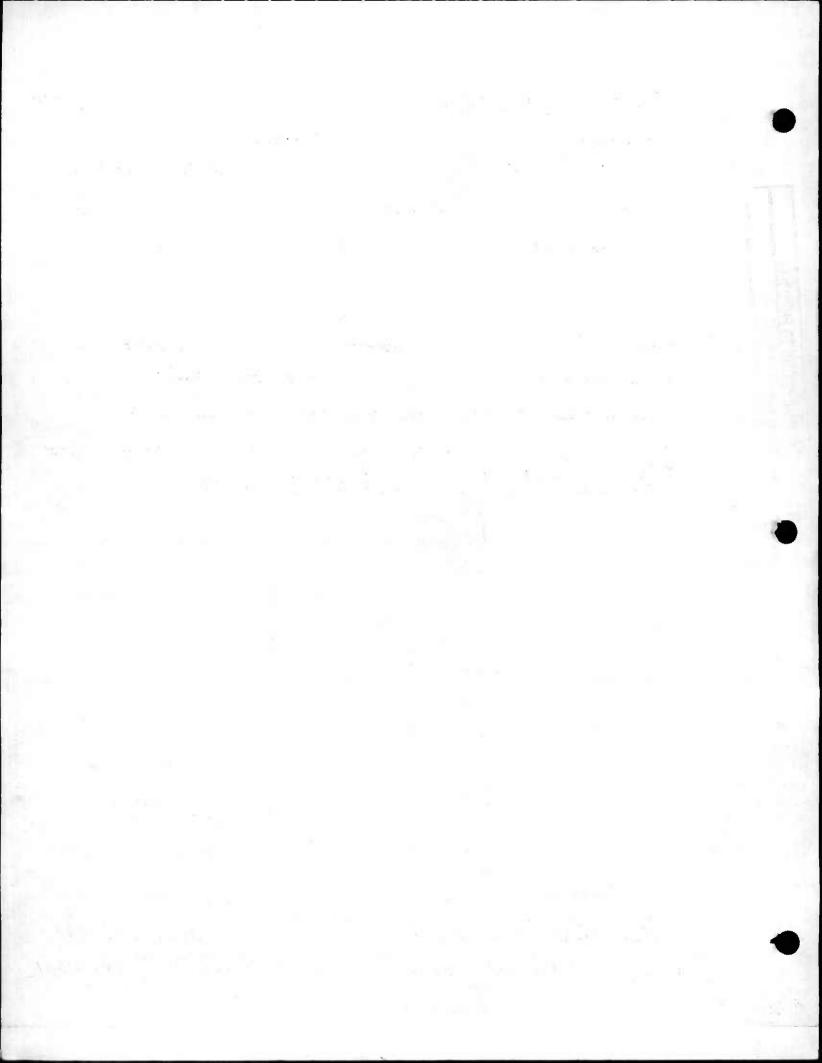
2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. 29a. Cartifier 29b. Signature and titla of cartifian 29d. Data signad (Month, Day, Year) 29c. License number and Specialist 100 M. Breadway, Baltinare, Maryland 21231 30, Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) WENGUSA NAVARRO MD. 31. Date filed (Month, Day, Year) 32. Register's Signature State

Julia Davidson-Mandale

DHMH 16 Bay 6/95

Registrar

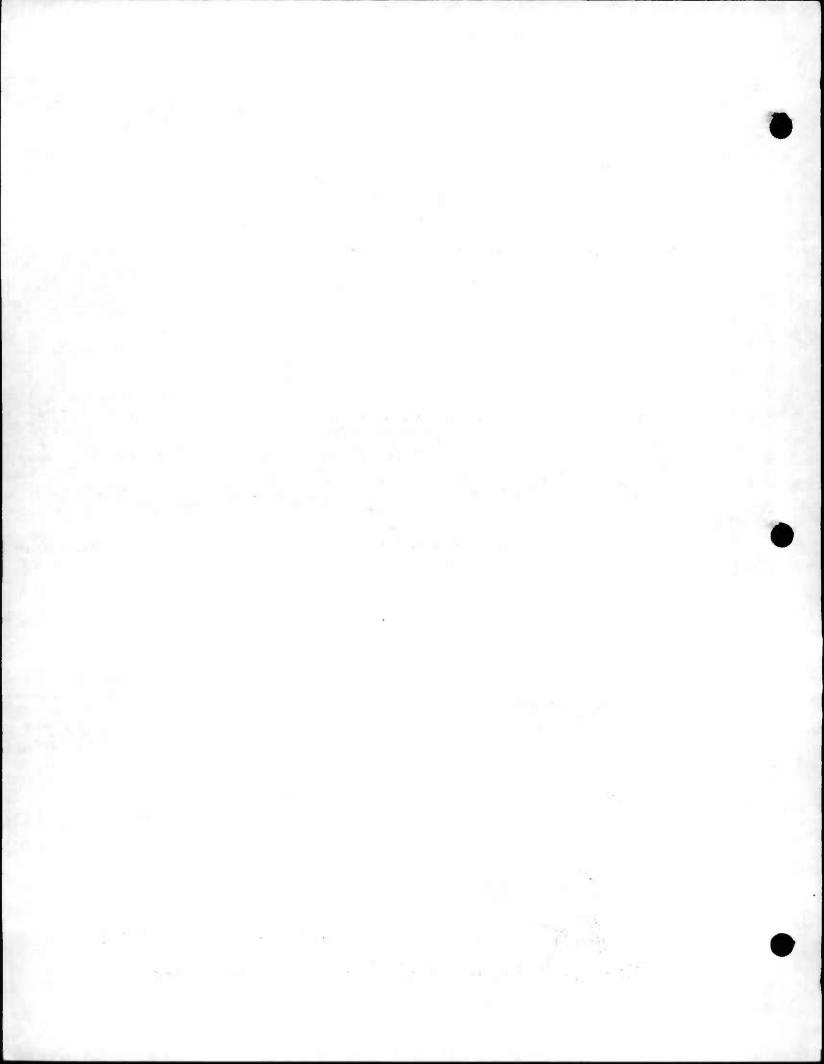
AUG



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8 2 3 4 9 2

			Certificate of Death		Reg. No.	C. U 4 J C.
	1. Decedent's Name (First, Middle, Las	0 0	0	2. Date of De		3. Time of Deeth
Physician /Medical		Annabell	Powers	July	7 7	998 6:49 A.H
Examiner	4a Facility Name (If not institution, give	street end number) Inns	of Evergreen 40. City, Town, o	r Location of Death		
		velescent	Battin	nore	N	
Funeral	5. Social Security Number 6. Se	7. Age (In yrs. last	birthday) If Under 1 Year if Under 24 H. Months Deys Hours Mi	n. (Month, De	th y, Year)	9. Birthplece (State or Foreign Country)
Director	2/7-26-7979 Usual Residence of Decedent	7 00	110.	3-15-	-1930	Ma
A ==	10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits
to to	Md n	A Ba	14 more			1 13 Yes 2 □ No
or items 23a or 28a-f show most must be notified at Funeral Director	10a. Street and Number		10f. Zip Code		10g. Citizen of V	Vhat Country?
23a o	1612 Ashburto	n Street	2/2/6		U.	S.A.
ne ne	11. Maritel Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Ortgin? If Yes, specify Cuban, Mexican, Put	(Specify Yes or No	- 14. Rec	a - American Indian, ik, White, etc.
F.	1 Never Married 2 Married	1 Yes 2 XNo	1 ☐ Yes 2 ☑ No Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify	
0	3 Widowed 4 Divorced	Year or Detes:				Glack
ete de	15. Decedent's Ed (Specify only highest grad	ucation 1 de com <i>pleted)</i>	6a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	vorking	16b. Kind of Bu	usiness/Industry
rt, the Medical I	Elementary/Secondary (0-12)	College (1-4or 5+)	C		wew Di	apery
C	17. Fether's Neme (First, Middle, Last)	/ / / /	Seam Stress 18. Mother's N	ame (First, Middle	Maiden Sumer	14+
or other traumatic event, the M To Be Comp	Johnnie Powe	σ	40.1	λ ,	,	
To To	19a. informent's Name/Reletionship (7		19b. Malling Address (Street end Number or	Rural Route Numb	er. City or Town	State, Zip Code)
6	2 6 2 11		11/20 E. Northum	Parkua	.1	. /
ther	20a. Method of Disposition	ey-Daughter 20b. Place	e of Disposition (Name of	Date	20c. Location -	40, Med 2/239 City or Town, State
	1) Burial 2 Cremation 3 🗆	Removal from State	etery, crematory or other plece)	8200	Anh	1.1
any Injury once.	4 Donation 5 Other (Specify	1//0	22. Name end Address of Facility	5-3-98	HIDAY	w, Ma
any injury or other ti once.	21. Signeture of Funeral Service Idean:	1/1	March F. H. Wes	+		21215
,	//Ell /	barch	4300 Wa	bach 4	renne	Ra 140, md
	23a. Rart. Enter the disease, or comp shock, or heert failure. List only of	licat less t hat ceused the deeth. I one cause on each line.	Do not enter the mode of dying, such as card	iac or respiretory e	rrest,	Approximate Intervel Between Onset and Death
cian	I dista Causa (Final	1	<i>R</i> .			Oriset and Death
lical iner	Immediate Cause (Final disease or condition resulting in death)	a	4 Ca			untimour
- I		Due to (or as	s e consequence of):			
hel-transit Examiner		b				
EXa	Sequentially list conditions, if eny, leading to immediate	Due to (or es	s e consequence of):			
s the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events	C	s e consequence of):			
as the bur	resulting in death) Last	Due to (or es	s e consequence or).			
ottending parties as to for use as to ician/Med		d				
d for	Part II. Other algorificant conditions of	ntributing to death but not resulting	ng In the underlying cause given In Part I.	23b. Did	tobacco use co	ntribute to the cause of death?
ached	1 /	(is in the original property and the contract of the contract o		Yes 2□ No	3 □ Probably 4 ☑ Onknown
e dat	13 pour	yen				
been signed by the ettendin should be datached for usa leted by Physician/N	/ '	U		24e. Was	en eutopsy ormed?	24b. Were autopsy findings available prior to
sho s				- pen	Jillieu i	completion of cause of death?
ate has been signed by the eitendi page 2 should be datached for us: Completed by Physician/				1□	Yes 2 No	1 ☐ Yes 2 ☐ No
certificate irector, pag o Be Co	25. Was cese referred to medical		26. Place of C	eath (Check only		
To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER		Home 5□ Resi		er (Specify)
Affer this certificate ha funeral director, page tion: To Be Com	27. Manger of Deeth		8b. Time of 28c. Injury et		how injury occur	
a fun	1 ☑ Natural 5 ☐ Pending investigation		Injury Work? M 1 Yes 2 No			
ector: After by tha funer tification	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street and Numb	per or Rural Route Number,
\$ 5 E	4 Homicide	building, etc. (Specify)		City or To	mi, Siate/	
al C	29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	dge, death occurred et the time, date end ple	ce, end due to the	ceuse(s) end me	enner as stated.
Presentative of the colors of	(Check only 2 Medical Exam	Iner: On the basis of examination and manner stated.	end/or Investigation, In my opinion, deeth oc	curred at the time,	date and place,	and due to the ceuse(s)
Eomi Eom	29b. Signature and title		29c. License number		-	d (Month, Day, Year)
	///dest	in	72766		7/31	164
	30. Name offd address of person while	empleted cause of death (Item 23	3a) (Type, Print)	0 1	(1/)	
	Men Het	Trucm 18	38 Greene Troo	Rul #	300	
State	31. Date iled (Month, Day, Year)	32 Registrar's Signature	1,000			
Registrar	AUG 3 1998	July Davidson-1	anounce		×	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 3:208 Johnny Lloyd Rush JULI /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Stella Maris at Mercy Hospital Baltimore N/A 5. Social Security Numbar 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth Month, Dey, Yeer) JAN 31, 1933 9. Birthplece (State or Foreign Country) South Carolina , Funeral Deys 1 ☑ M 2 □ F Months Hours 213-26-1766 65 **Director** Usuel Residence of Decadent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-4 show any injury or other traumatic event, the Medical Examinal must be notified a page. KUSH, JOHNNY Director 1 Yes 2 No MD N/A Baltimore 10e. Straat and Number 10f. Zip Code 10g. Citizen of What Country? 1125 Riggs Avenue 21215 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. Armed Forces: 1 ☑ Yes 2 ☐ No If Yes, Give 1953— Yeer or Detes: 1959 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: 21215-002(þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Methodist Church Minister Saltimore, Maryland 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) John Lloyd Rush Janie Mae McFadden 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1739 Waverly Way APT. D Baltimore, MD 21239 Pearl Rush / Wife 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Metro Crematory, Inc.07/31/98 Baltimore, MD 21. Signature of Funeral Service Licensee

Edward A. Gregorchik 22. Nama and Address of Fecility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errast, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final diseese or condition resulting In deeth) /Medical METASTATIC ESOPHAGEAL CANCER Examiner UNKNOWN Due to (or as e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as a consequence of): or Attending Physician: The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) STELLIA MARIS AT IYER (I) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 Yes 2 No this 28c. Injury et Work? Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation s efter death.

if Director: Aff 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28a. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C completely filled Hospital Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and menner as stated.

Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred at tha tima, data and place, and due to the ceuse(s) end manner steted. edicai (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Il Down ma 040480 JULY 29, 1999 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Belain 5810 FERNANDO V. FERRO, MO 21206 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State the Davidson-Randell Registrar

A WOOM DOLLAND

Will live

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death MARGARET RUBINSON EARLINE 24 1998 16:25 JULY 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Qaath BALTIMORE SAINT AGNES HOSPITAL, 900 CATON AVENUE If Undar 1 Yaar Months Days If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) 1□M 2KF 213-32- 9286 Usual Residence of Dacadant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits PRYES 2 No BALTIMORE Harylow 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3814 2/229 HARIEN USA 12. Was Dacadant Evar In U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 22 No If Yas, Giva Year or Datas: 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) HAVYLORD Collaga (1-4or 5+) ACKEN 1248ms 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) BRYON WERNER Smith MILTON 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) BALLINE Glanplons, 20c. Location - City or Town, State RUBINSON HUSBAND 20b. Place of Disposition (Name of cemetary, crametory or other place) 20a. Mathod of Disposition Data Burial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify) 7/30/ Forest Veterare Cing 22. Nama and Addrass of Facility CHA-dIAN - HAMS F. N 21. Signatura of Funaral Sarvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final diseasa or condition rasulting In daath) Sequentially list conditions, if any, laading to Immediate causa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to dath but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa 24a. Was an autopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumetic event, the Modical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or item any injury or other traumatic event

Baltimore, Maryland 21215-0020

Certification:

the pege 2 should be of a Attending Person of the death

buriel-transit

Physician/Medical Completed Be 2

ion of Vital Records, P.O. Box 68760, To the Hospital of within 24 hours er

> State Registrar

Medicai

29b. Signatura and titla of certitiar

axaminer'i 1 Yas 2 No

27. Mannar of Death

2 Accidant 3 Suicida

4 | Homicide

29a. Certifier

Netural

28a. Data of Injury (Month, Day Year)

1 ☐ Inpatiant ☐ ER/Outpatient 3 ☐ DOA

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Tima of

29c. Licansa numbar

28c. Injury at Work?

1 Yes 2 No

Certifying Physician: To the best of my knowledga, daath occurred at the time, date end plece, and dua to tha ceusa(s) and mannar as statad.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end placa, and dua to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

of daath (Itam 23a) (Type, Print)

31. Date filad (Month, Day, Year) AUG

5 Pending invastigation

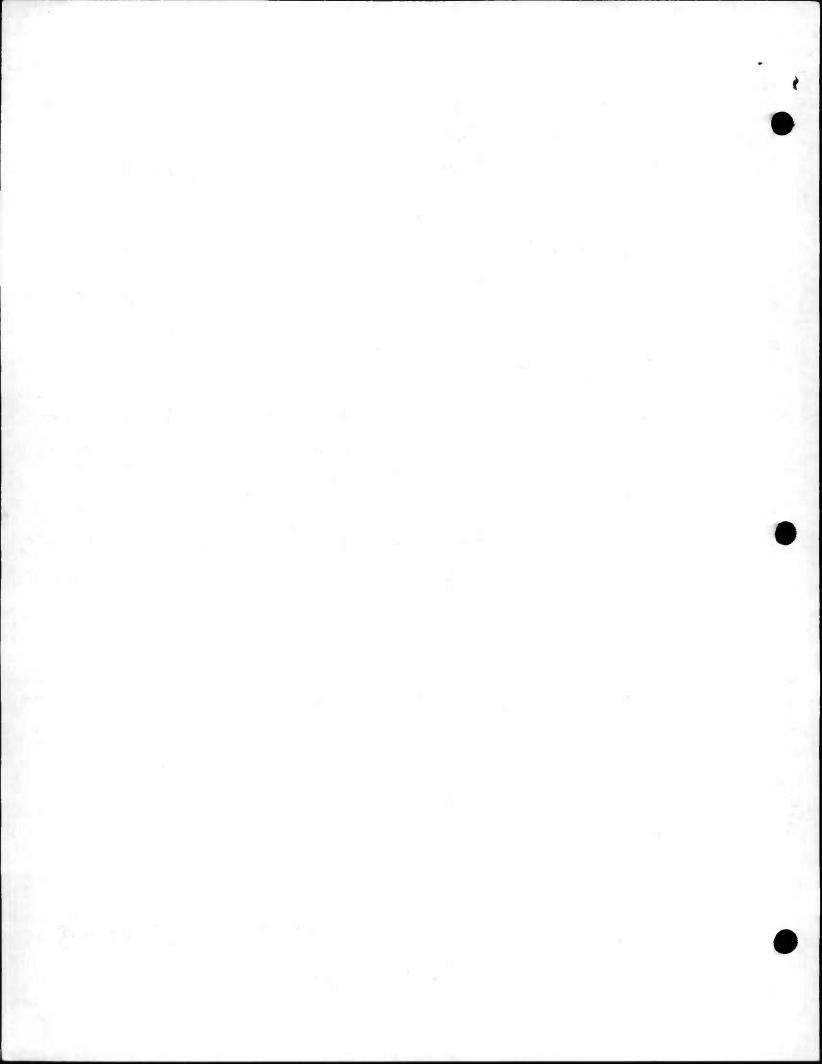
6 Could not be datemined

32. Registrar's Signatu Full Davidson

26. Placa of Death (Check only ona)

Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)

28d. Describe how injury occurred

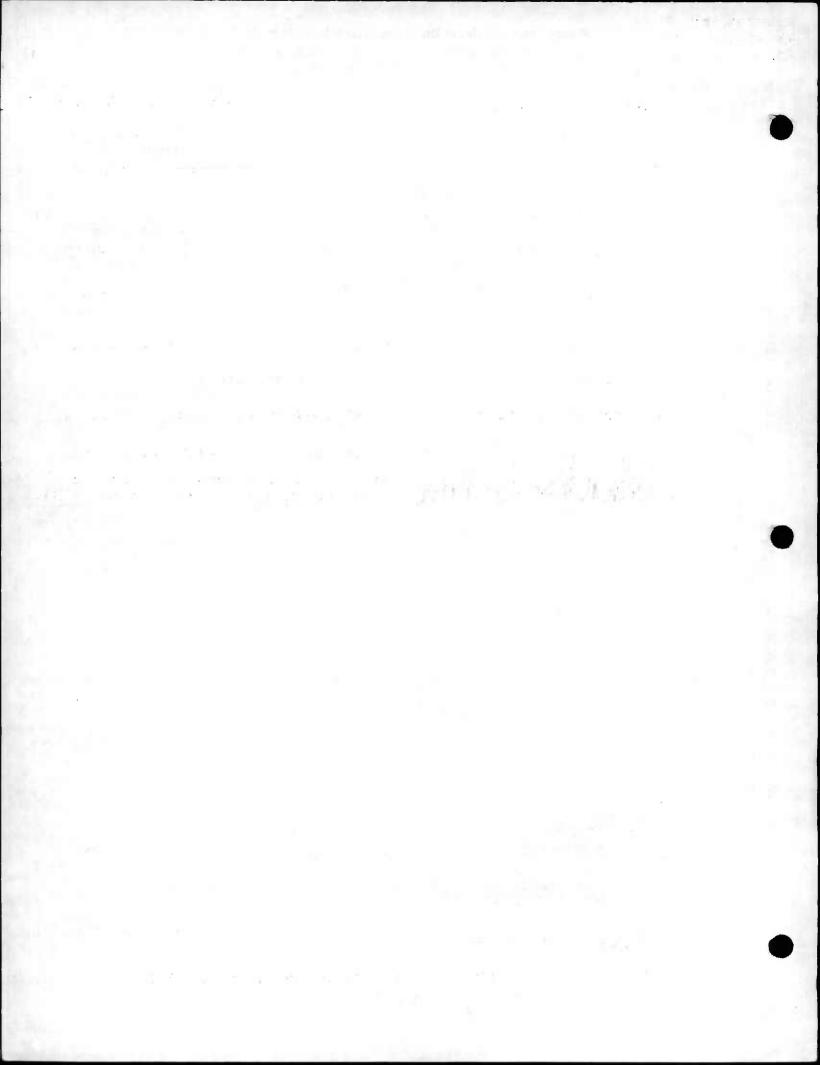


ROBERT SNYDER 98-4279-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	n#8 per FH G762 8/3/98 1. Decedent's Nama (First, Middle, L			Cer				2. Date of D			3. Tima of	Death
hysician Medical	Robert A. Snyo	der, Sr						JULY	Up 2	27, 1998	0921	A
xaminer	4a Facility Name (If not institution, ga		m <i>ber</i>)			4b. C	city, Town, o	r Location of Dea	th 4c	. County of Dea	ith	
	ST. AGNES HOSPIT				WT1-4-43		TIMOF			Baltim		
neral ector	5. Social Security Number 6. 220 – 82 – 1471	Sax 1X0 M 2□ F	7. Age (In yrs 3 7	. last birthday) Yrs.	Months D		Under 24 H lours M		ay, Year;	//60 9. Bi	rthplaca (Stata o country) yland	r Foraig
tor	Usual Residence of Decedant		37					1-21-	30-	Flat	yrand	
	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside Ci	
ctor	Md. Balti	imore		Balti	more						1 □ Yes	XX No
Director	10e. Street and Number				10f. Zip Co					tizen of What C	- 111-	
Funeral	4231 McDowell					2122				ited S		
by rune	11. Marital Status 1 □ Navar Marriad 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Fo	ve XNo		Yes, specify			(Specify Yes or Narto Rican, atc.)	0-	14. Raca - Am Black, Whi Specify: W	ite, atc.	
P	15. Decedent's E	Education		16a. Daced	ant's Usual C	Occupation	1	Div.	16b. k	(ind of Business	s/Industry	
ple	(Specify only highast g Elementary/Secondary (0-12)	rada complated) Collega (1-4or 5+)	lifa. L	ant's Usual C kind of work of OO NOT usa i	ratired)	ng most of w	orking				
= ° > m	8									onstru	ction	
	17. Fathar's Name (First, Middle, Las	at)						ame (First, Middi		n Surname)		
	Roy E. Snyder	(Tuna Drive)		105 44-20	n Address 10			Lizer	_	or Town Chair	Zin Cadal	
	19a. Informant's Name/Ralationship Clara McMuller		r					Ru <i>ral Route N</i> um ne, Bal	-			
	20a. Method of Disposition	1-610 6116		Place of Dispo camatery, cran			T Dai	Date	_	ocation - City o		
	1 Burial 2 Cramation 3 4 Donation 5 Other (Spec	Removal from	Stata				oria	 7-31-9				
	21. Signature of Funeral Service Lice		11		. Name and A			L1-31-9	OEI	riidge		
	23a. Part1. Enter the disease, or conshock, or haart failure. List only	12/v	106	χ_0	mbros	se F	uner	al Home	of	Lansd	owne	212
fedical Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c		or as a consaq								
any		d							-		1	
/sici	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the ur	nderlying caus	se given l	n Part I.	23b. DI	d tobacc	o use contribut	te to the cause	of deat
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been signed by the attending F should be detached for use as leted by Physician/Me								24a. Wa	s an auto formed?	opsy 24b	. Wara autopsy available prior to completion of cof death?	to
pleted by P								1			30% 00	No
completed by P								18	Yes 2	No	1 Yes 2	
3e Completed by Physician/Medical	25. Was case raterrad to medical					26	S. Placa of [1E		2□No	19 Yes 2L	
Be	axaminer? XIX Yes 2□ No			☐ ER/Outpatien		Other:			one)			
To Be	axaminer? XIX Yes 2 □ No 27. Manner of Death 1 M Natural 5 □ Panding 2 □ Accident investigati	28a. Date (Mon	of Injury th, Day Year)	28b. Tima of Injury	28c	Other: Injury at Work? 1 Yes		Home 5 Ra	one) sidence how inju	6 □Other (Sp ury occurred	ecify)	
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completely filled in by the funeral director, page 2 should be del Medical Certification: To Be Completed by P	axaminer? X	28a. Date (Mon be build) 28e. Place build) Thyalclan: To the building and man	of Injury th, Day Year) a of Injury - At the ing, etc. (Special best of my kn asis of examin ner stated.	28b. Tima of Injury homa, farm, stri ify) owledge, death ation and/or inv	M 28c. M oset, factory, o occurred at tastigation, in 29c. L	Other: Injury at Work? 1 Yes office the tima, or my opinic.	4 Nursing 2 No data and place on, death or	peath (Check only) Home 5 Ra 28d. Describe 28f. Location City or T	one) sidence how inju (Street a own, State causa(s) date ar 29d. Do	6 □Other (Sp ury occurred and Number or Nete) s) and manner and place, and du ata signad (Mor	Pural Route Num as stated. ue to the cause(anth, Day, Year)	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) JULY **Physician** 30 1998 10:30p STEFFE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT 3, 1930 5. Sociel Security Number 7. Age (in yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** MARYLAND 1 □ M 212 F Yrs. Director 212260809 10c. City, Town or Location 10a. Stete 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21237 8312 ANALEE AVENUE USA Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Maritel Status Pages 1 and 2 should be filed within 72 hours atter and of Health and Mantal Hygiene. and If Item 72 is marked other than "naturat", or the ury or other treumatic event, the Medical Estamities 1 Never Married 2 Married 1 ☐ Yes ZV No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE 12 0 ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be PERNELL GADOW MARTE RIEDEL. 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DONALD L. STEFFE / HUSBAND 8312 ANALEE AVE ROSEDALE, MD 21237 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremetion 3 □ Removel from Stete permit. Page Department of Important: if any injury or once. 7/3/98 HOLY CROSS BALTIMORE, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel UNKNOWN CIRRHOSIS disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ESOPHAGEAL VARICES þ 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed HEPATIC ENCEPHALOPATHY completion of cause of deeth? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medicel examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Nopatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Deeth Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 XNeturel 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed of Vital Records, P.O. Box 68760 for use as signed by the a should certificate has t Physicien: director, Attending F Division

the Maryland

death with

Baltimore, Maryland 21215-0020

24 hc Fune To the Hose within 24 ho To the Fund completely fi

edicai

29a. Certifier

(Check only

29b. Signature and title of

29c. License number

15 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

RES - 000

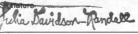
July 30, 1998

30. Name and address of person who completed cause of death (Item 230) (Type, Print)

Matthews Chacko Dept. of Medicine Johns Hopkins Hospital Bultimore, MD 21205

State Registrar 31. Dete filed (Month, Day, Year) 32. Registrer's Spriate 1998 AUG 3

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tem othe		20e. Method of Disposition			20b. P		sition (Nema of natory or other pla		Dete	20c. Location -		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Day Satherine Stankowski 7:20 AM 1998 August 02 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER N/A BALTIMORE 7. Age (In yrs. lest birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 9. Birthplace (Stete or Foreign 1 M 2 F 214-24-2412 SOUTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 No Yes 2 No MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1822 FLEET STREET 21231 U.S.A. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Raca - American Indian, Biack, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED TAVERN 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) JOHN WREDEN ROSALIE GROOMES 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MR. WALTER T. STANKOWSKI 1822 FLEET ST. BALTIMORE, MD. 21231 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2. Cramation 3 ☐ Removal from State GREENMOUNT CREMATORY 8/6/98 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licensee 22 KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224 moroush 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebre Vascular Due to (or as a consequence of) Devere Uncontrolled Due to (or as a consequence of) Due to (or as a consaquanca of)

Physician /Medical **Examiner**

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Physician/Medical Examiner

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Certification:

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10a. State

Director

Funeral

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ype 2 DM, atrial fil,

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☑ Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25.	Was cese		to	medicel	
	examiner?				
	1 ☐ Yes	2 No			

5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of

28c. injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who completed faure of death (item 23e) (Type, Print)

State Registra

31. Date filed (Month, Day, Year) 3 1998 AUG

32. Registrar's Signature fulia Davidson-Randalle

DHMH 16 Rev 6/95

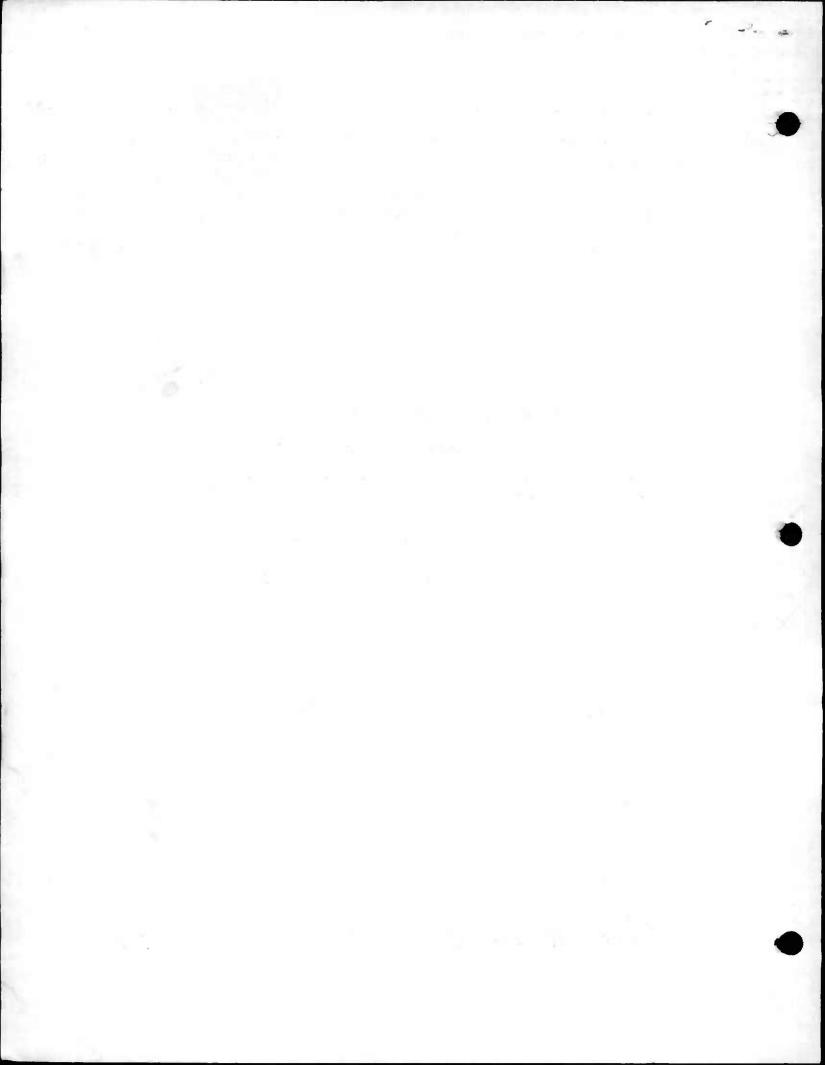
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The law requires that the death certificate signed by this certificate has or Attending Physician: s after death.

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P.O. Box 6876 Records, of Vital

Division



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